The Senate

Standing Senate Committee on Social Affairs,
Science and Technology

The Health of Canadians - The Federal Role

Final Report on the state of the health care system in Canada

Chair:
The Honourable Michael J. L. Kirby

Deputy Chair:
The Honourable Marjory LeBreton

October 2002

Volume Six: Recommendations for Reform

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The Standing Senate Committee on Social Affairs, Science and Technology

Final Report on
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Volume Six:
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ORDER OF REFERENCE

Extract from the Journals of the Senate of Tuesday, October 8, 2002:

Resuming debate on the motion of the Honourable Senator Kirby seconded by the Honourable Senator Pépin:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report upon the state of the health care system in Canada. In particular, the Committee shall be authorized to examine:

a) The fundamental principles on which Canada's publicly funded health care system is based;
b) The historical development of Canada's health care system;
c) Health care systems in foreign jurisdictions;
d) The pressures on and constraints of Canada's health care system; and
e) The role of the federal government in Canada's health care system;

That the papers and evidence received and taken on the subject and the work accomplished during the Second Session of the Thirty-sixth Parliament and the First Session of the Thirty-seventh Parliament be referred to the Committee;

That the Committee submit its final report no later than October 31, 2002;

That the committee retain the powers necessary to publicize its findings for distribution of the study contained in its final report for 60 days after the tabling of that report; and

That the Committee be permitted, notwithstanding usual practices, to deposit any report with the Clerk of the Senate, if the Senate is not then sitting; and that the report be deemed to have been tabled in the Chamber.

The question being put on the motion, it was adopted.

ATTEST :

Paul C. Bélisle
Clerk of the Senate

SENATORS

The following Senators have participated in the study on the state of the health care system undertaken by the Standing Senate Committee on Social Affairs, Science and Technology:

The Honourable Michael J. L. Kirby, Chair of the Committee
The Honourable Marjory LeBreton, Deputy Chair of the Committee

and

The Honourable Senators:

Catherine S. Callbeck
Joan Cook
Jane Cordy
Joyce Fairbairn, P.C.
Wilbert Keon
Yves Morin
Lucie Pépin
Brenda Robertson
Douglas Roche

Ex-officio members of the Committee:
The Honourable Senators: Sharon Carstairs, P.C. (or Fernand Robichaud, P.C.) and John Lynch-Staunton (or Noel A. Kinsella)

Other Senators who have participated from time to time on this study:
The Honourable Senators Atkins, Banks, Beaudoin, Carney, Cochrane, Cohen,* DeWare,* Ferretti Barth, Grafstein, Graham, P.C., Hubley, Joyal, P.C., Lawson, Léger, Losier-Cool, Maheu, Mahovlich, Meighen, Milne, Murray, Rompkey, St. Germain, Sibbeston, Stratton, Tunney*, and Wilson*

* retired

LIST OF ABBREVIATIONS

ACAHO	Association of Canadian Academic Healthcare Organizations
ACMC	Association of Canadian Medical Colleges
ACST	Advisory Council on Science and Technology
AHSC	Academic Health Sciences Centre
CAN	Canadian Nurses Association
CAPE	Clinicians Assessment and Professional Enhancement
CBAC	Canadian Biotechnology Advisory Committee
CCAC	Canadian Council on Animal Care
CCHSA	Canadian Council on Health Services Accreditation
CCN	Cardiac Care Network of Ontario
CCOHTA	Canadian Coordinating Office for Health Technology Assessment
CDPAC	Chronic Disease Prevention Alliance of Canada
CFI	Canada Foundation for Innovation
CHA	*Canada Health Act*
CHSRF	Canadian Health Services Research Foundation
CHST	Canada Health and Social Transfer
CIAR	Canadian Institute for Advanced Research
CIDA	Canadian International Development Agency
CIHI	Canadian Institute for Health Information
CIHR	Canadian Institutes of Health Research
CLSC	*Centre local de services communnautaires* (community health centre)
CMA	Canadian Medical Association
CPP	Canada Pension Plan
CRC	Canada Research Chairs
CSTA	Council of Science and Technology Advisors
CT	Computed Tomogram (scan)
DND	Department of National Defence
DRG	Diagnostic Related Group
EHR	Electronic Health Record
EI	Employment Insurance
EMP	Extra-Mural Program
EPF	Established Programs Financing
F/P/T	federal/provincial/territorial
FAE	Fetal Alcohol Effects
FAS	Fetal Alcohol Syndrome
FFS	Fee-for-service
FHN	Family Health Networks
FMG	Family Medicine Groups
GDP	Gross Domestic Product
GP	General Practitioner
HRDC	Human Resources Development Canada
HTA	Health Care Technology Assessment
HTF	Health Transition Fund
ICH	International Conference on Harmonization
ICT	information and communications technologies
IDRC	International Development Research Centre
IMG	International Medical Graduates
IT	Information Technology
JPPC	Joint Policy and Planning Committee
LPN	Licensed Practical Nurse
MEF	Medical Equipment Fund

MOHLTC	Ontario Ministry of Health and Long-Term Care
MRC	Medical Research Council of Canada
MRI	Magnetic Resonance Imaging
MSA	Medical Savings Account
NACA	National Advisory Committee on Aging
NBEMH	New Brunswick Extra-Mural Hospital
NCEHR	National Council on Ethics in Human Research
NHEX	National Health Expenditure Database
NHRDP	National Health Research and Development Program
NHS	National Health Service
NRC	National Research Council
NSERC	Natural Sciences and Engineering Research Council
ODB	Ontario Drug Benefit
OECD	Organisation for Economic Co-operation and Development
OFHN	Ontario Family Health Network
OHA	Ontario Hospital Association
OMA	Ontario Medical Association
PAHC	Post-Acute Home Care
PCG	Primary Care Groups
PCN	Primary Care Network
PCR	Primary Care Reform
PCT	Primary Care Trust
PENCE	Protein Engineering Network of Centres of Excellence
PET	Positron Emission Tomography (scan)
PHCTF	Primary Health Care Transition Fund
PIPEDA	*Personal Information Protection and Electronic Documents Act*
PMSI	*Programme de Médicalisation du Système d'Information*
PPP	Purchasing Power Parity
PPS	Prospective Payment System
QPP	Quebec Pension Plan
REB	Research Ethics Board
RHA	Regional Health Authority
RHC	Regional Hospital Corporation
RN	Registered Nurse
Rx&D	Canada's Research-Based Pharmaceutical Companies
SSHRC	Social Sciences and Humanities Research Council
TCPS	*Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*
UBC	University of British Columbia
URS	Urgency Rating Score
WCB	Workers' Compensation Board
WCWL	Western Canada Waiting List

ACKNOWLEDGEMENTS

The Committee wants to publicly acknowledge the enormous assistance it has received during the past two years from those who have worked so hard in helping the Committee to produce its six reports.

The Committee particularly wants to express its deep appreciation to:

- Odette Madore and Dr. Howard Chodos of the Research Branch of the Library of Parliament, the full-time research staff of the Committee, who have been deeply involved in all drafts of the six reports that the Committee has released during this study. Without their extraordinary help, these reports would not have been completed in such a short time, nor in such a competent manner.
- Catherine Piccinin, the Committee Clerk and her Administrative Assistant, Debbie Pizzoferrato, who were responsible for organizing all the meetings the Committee held on the health care issue, including scheduling the appearances of all the witnesses, for overseeing the translation and printing of all six reports, and for responding to thousands of requests for information about the Committee's work and for copies of the Committee's reports.
- Dr. Duncan Sinclair, the former chair of the Health Services Restructuring Commission of Ontario, who gave so generously of his time and expertise in reviewing, editing and offering suggestions for improvement in all of the drafts of the Committee's reports.
- The staff of each of the members of the Committee, who have had to endure a substantially increased work load for the past two years.

To all of these people, we express our heartfelt thanks for a job very well done.

The Committee worked long hours over many months, requiring the services of a large number of procedural, research and administrative officers, editors, reporters, interpreters, translators, messengers, publications, broadcasting, printing, technical and logistical staff who ensured the progress of the work and reports of the Committee. We wish to extend our appreciation for their efficiency and hard work.

FOREWORD

This report is the culmination of a two-year study by the Standing Senate Committee on Social Affairs, Science and Technology. During this period, the Committee has heard the views of over 400 witnesses. The Committee wishes to express its sincerest thanks for the effort these witnesses made to give us their advice on what needs to be done to reform Canada's health care system and make it fiscally sustainable.

As one would expect, given the complex, ideological and political nature of health care issues, the advice we received was often conflicting. Nevertheless, the Committee considered seriously the views of all the witnesses in arriving at our recommendations.

The recommendations in this report reflect the *unanimous* view of the eleven Senators on the Committee (seven Liberals, three Progressive Conservatives, and one Independent). The experience of the eleven Committee members in public policy and health-related issues is as deep as it is varied. The Committee includes:

- two doctors: Yves Morin, a former Dean of Medicine at Laval University, and Wilbert Keon, the Chief Executive Officer of the Ottawa Heart Institute;
- two former provincial ministers of health: Brenda Robertson and Catherine Callbeck, who was also a provincial premier;
- two former Members of Parliament: Douglas Roche and Lucie Pépin, who was also a nurse;
- a former federal cabinet minister and former journalist: Joyce Fairbairn;
- two community activists: Joan Cook, who served for many years on various hospital boards, and Jane Cordy, who was also a teacher;
- two former senior members of a Prime Minister's office: Marjory LeBreton and Michael Kirby, who was also a former federal Secretary to the Cabinet for Federal-Provincial Relations.

The Committee believes that its recommendations meet *the four objectives the Committee set for itself at the outset of its work:*

- To formulate a detailed, concrete *plan of action* that did not focus heavily on governance issues or intergovernmental structures;
- To attach a *cost* to its recommendations and propose a specific *revenue raising plan*. For its report to be truly useful, the Committee felt it could not be vague on the question of precisely how its recommendations would be funded;
- To specify clearly the *changes* that each of the major stakeholders – individual Canadians, health care professionals, provincial and federal governments, etc. – would have to make so that the Committee's reform plan could be implemented successfully.

- To make clear the *consequences of not changing*, and hence of not reforming, the health care system.

The Committee feels that there is a real window of opportunity for implementing the kind of reform that is needed to ensure the long-term sustainability of Canada's health care system. The Committee believes it has worked out a detailed, concrete and realistic plan which, if implemented integrally, would lead to the strengthening of the publicly funded health care system in Canada and help guarantee its sustainability for the foreseeable future. It looks forward to pursuing its work in this direction, along with all those who share this objective.

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The health of the people is really the foundation upon which all their happiness and all their powers as a state depend.

Benjamin Disraeli – July 24, 1877

It is to the Canadian people, and their improved health, that the Committee dedicates this report.

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INTRODUCTION

For the past two years the Standing Senate Committee on Social Affairs, Science and Technology has been studying the state of the Canadian health care system and the federal role in that system. The Committee has sat for over 200 hours and held 76 meetings. Most of these meetings were public sessions during which the Committee heard from over 400 witnesses, many of whom represented organizations that have thousands of members (such as the Canadian Medical Association and the Canadian Nurses Association).

To date the Committee has published five reports. This sixth report contains the Committee's final recommendations for reform and renewal of the Canadian health care system. These recommendations flow from the principles enunciate in Volume Five.The major topics covered in the five previous reports, as well as the subjects to be treated in future reports, are summarized in the following table:

Phases	**Content**	**Timing of Report**
One	Historical Background and Overview, Myths and Realities	March 2001
Two	Future Trends, Their Causes and Impact on Health Care Costs	January 2002
Three	Health Care Models and Practices in Other Countries	January 2002
Four	Issues and Options	September 2001
Five	Principles for Restructuring the Hospital and Doctor System and Recommendations on Several Health Care Issues	April 2002
Six	Recommendations with respect to Financing and Restructuring the Hospital and Doctor System and Closing the Gaps in Drug and Home Care Coverage	October 2002
Thematic Studies	Aboriginal Health, Women's Health, Mental Health, Rural Health, Population Health, Home Care and Palliative Care	At future dates to be determined

As the table indicates, following the release of this report, the Committee intends to examine a number of additional health-related issues. These studies will result in a series of thematic reports on: 1) Aboriginal health; 2) women's health; 3) mental health; 4) rural health; 5) population health, including literacy issues; 6) home care; and 7) palliative care.

In addition, the Committee held public hearings in September 2002 to examine the document *French-Language Healthcare – Improving Access to French-Language Health Services*, a study coordinated by the Fédération des communautés francophones et acadiennes du Canada for the Consultative Committee for French-Speaking Minority Communities. The Committee will be releasing a report on this issue, and readers of this volume are strongly encouraged to read that report as well.

The recommendations contained in Volume Six can be grouped into six categories:

- recommendations on restructuring the current hospital and doctor system to make it more efficient and more effective in providing timely and quality patient care;
- recommendations on enacting a health care guarantee that would ensure that patients receive treatment within a specified maximum amount of time for major hospital or diagnostic procedures; if the waiting time is exceeded, the health care guarantee would require the insurer/government to pay the cost of the patient receiving the necessary service in another jurisdiction or another country;
- recommendations on expanding public health care insurance to include coverage for catastrophic prescription drug costs, immediate post-hospital home care costs, and costs of providing palliative care for patients who choose to spend the last weeks of their lives at home;
- recommendations that strengthen the federal contribution to, and role in, developing health care infrastructure, including health information systems, health care technology, the evaluation of health care system performance and outcomes, the supply of health human resources, health research, wellness promotion and illness prevention, and the nation's 16 Academic Health Sciences Centres;
- recommendations on how additional federal revenue should be raised, and on how this new revenue should be administered in a transparent and accountable manner in order to implement the recommendations in this report;
- observations on the consequences that would arise if the additional federal revenues that the Committee recommends be raised are not invested in the health care system.

As some of these recommendations will require the financial participation of the provincial and territorial governments if they are to be implemented, the Committee is keenly aware of the importance of fostering a spirit of cooperation and collaboration amongst the various levels of government in the course of working to reform and renew Canada's health care system.

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Part I: Accountability

CHAPTER ONE

THE NEED FOR AN ANNUAL REPORT ON THE STATE OF THE HEALTH CARE SYSTEM AND THE HEALTH STATUS OF CANADIANS

To formulate realistic recommendations to improve the provision of health care services to Canadians, it is necessary first to have a clear view of the health care system now and an assessment of its strengths and weaknesses. From the outset, the Committee has sought to portray accurately the reality of Canada's health care system and to separate myth from fact.[1]

The Committee believes that an ongoing evaluation of the health care system is essential, conducted in as objective a fashion as possible. In this chapter the Committee presents its recommendations for the creation of a new National Health Care Council chaired by a Health Care Commissioner charged with carrying out this task by producing an annual report on the state of the health care system and the health status of Canadians.

Before turning to this, however, we begin with a brief review of some key elements from previous volumes of the Committee's study. These summarize the basic approach that the Committee has adopted in the course of its multi-volume study, as well as the objectives it has sought to achieve in developing its recommendations.

1.1 Summary of Some Key Points from Volumes One through Five

1.1.1 The role of the federal government

The Committee identified the various roles of the federal government in health and health care; Volume Four set out these roles, together with a set of policy objectives for each.[2] The Committee also affirmed the legitimacy and importance of the federal government's roles from a number of perspectives:

- First, it is clear that Canadians strongly support national principles in health care and look to the federal government to play an important role in maintaining these principles;
- Second, federal funding for health care is especially critical at this time of reform and renewal. As the Committee makes clear in the present volume, making changes in the way the health care system is structured and operates will require spending more money - money that must be raised primarily by the federal government;
- Third, and some would say most important, only the federal government is in a position to make sure that all provinces and territories, regardless of the size

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[1] See Volume One, *The Story So Far*, Chapter Six, Myths and Realities, pp. 93ff.

[2] See Volume Four, *Issues and Options*, Chapters Three and Four, pp. 9-26.

of their economies, have at their disposal the financial resources to meet the health care needs of their citizens. This redistributive role of the federal government is fundamental to what many call "the Canadian way."

- Fourth, fundamental changes to the health care system should not be confined to one or two provinces. Our national system requires inter-provincial harmonization in which the federal government has a crucial role to play, through, for example, its use of financial incentives and/or penalties to encourage provincial and territorial governments to adopt country-wide standards.
- Fifth, the Committee believes strongly that the substantial sums of money transferred by the federal government to the provinces and territories for health care should ensure that the federal government has a seat at the table when restructuring of the health care system is discussed. The principle of accountability to the taxpayers requires the federal government to have a say in how that money is spent.

It is very clear to the Committee that Canadians want the provinces, the territories and the federal government to work collaboratively in partnership to facilitate health care renewal. Canadians are impatient with blame-laying; they want intergovernmental cooperation and positive results.

Finally, it is very clear to the Committee that Canadians want the provinces, the territories and the federal government to work collaboratively in partnership to facilitate health care renewal. Canadians are impatient with blame-laying; they want intergovernmental cooperation and positive results.

1.1.2 Objectives of federal health care policy

The Committee has pointed out that federal policy in health care flows from two overarching objectives – objectives that the Committee strongly supports as the primary goals to be pursued by the federal government in the field of health care. These two objectives are:

- *To ensure that all Canadians have timely access to medically necessary health services regardless of their ability to pay for these services.*
- *To ensure that no Canadian suffers undue financial hardship as a result of having to pay health care bills.*

***The Committee believes that federal policy in health care flows from* two objectives:**

- **To ensure that all Canadians have timely access to medically necessary services regardless of their ability to pay for these services.**
- **To ensure that no Canadian suffers undue financial hardship as a result of having to pay health care bills.**

Implicit in these two objectives, particularly the first, is the requirement that the medically necessary services provided under Medicare be of high quality. Clearly, providing access to services of inferior quality would defeat the purpose of Canada's health care system.

With respect to the pre-eminent piece of federal legislation in health care, the *Canada Health Act* (1984), the Committee has repeatedly expressed its unqualified support for the four patient-oriented principles in the *Canada Health Act.* The Committee has also endorsed the intent of the fifth principle of the *CHA*, although it is of a different character:

- The principle of **universality**, which means that public health care insurance must be provided to all Canadians;
- The principle of **comprehensiveness**, which is meant to guarantee that all medically necessary hospital and doctor services are covered by public health care insurance;
- The principle of **accessibility**, which means that financial barriers to the provision of publicly funded health services, such as user charges, are discouraged, so that needed care is available to all Canadians regardless of their income;
- The principle of **portability**, which means that all Canadians are covered under public health care insurance, when they travel within Canada or move from one province to another.
- The principle of **public administration** does not focus on the patient but "is rather the means of achieving the end to which the other four principles are directed."[3] The public administration condition of the *Canada Health Act* is the basis for the single insurer/funder model that the Committee has endorsed in Volume Five under Principle One.[4] This condition of the Act requires provincial and territorial health care insurance plans to be managed on a not-for-profit basis by a public agency.

The Committee has also agreed with the Honourable Monique Bégin, the federal Minister of Health at the time that the *Canada Health Act* was passed, that the principle of public administration has come to be misunderstood.[5] The Committee strongly supports the single-payer insurance system whereby the government is the funder of hospital and doctor services. The public administration principle refers to the *funding* of hospital and doctor services, ***not to the delivery*** of those services.

The principle of public administration has come to be misunderstood. The Committee strongly supports the single-payer insurance system whereby the government is the funder of hospital and doctor services. The public administration principle refers to the funding of hospital and doctor services, not to the delivery of those services.

The misunderstanding of the principle of public administration has arisen out of the confusion between publicly funded and administered health insurance and the actual delivery of health care services themselves. Under the *Canada Health Act*, services do not have to be delivered by public agencies. Indeed, in Canada today the great majority of health care services are delivered by a variety of private providers and institutions.

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[3] Volume One, p. 41.

[4] Volume Five, pp. 23-25.

[5] See her testimony before the Committee, May 8, 2002 (54:5).

The Committee reaffirms its commitment to the principle that every Canadian should be guaranteed access to medically necessary services by a publicly funded and administered insurance program, everywhere in Canada. This has been the essence of Canadian health care policy for over 30 years, and is clearly reflected in the *Canada Health Act*.

Pursuit of the objectives of Canadian health care policy involves a "contract" between Canadians and their governments – federal, provincial and territorial. Canadians pay taxes to their governments, which then use the money (in part) to fund a universal insurance plan that provides to all Canadians first-dollar coverage for medically necessary services delivered by hospitals and doctors. These services must be accessible, comprehensive, and portable among provinces and territories. The "contract" requires governments (federal and provincial/territorial) as insurers, to use the funds collected from Canadians to meet the two policy objectives stated above, i.e., to ensure that Canadians are publicly insured and have timely access to medically necessary hospital and doctor services of high quality.

1.1.3 The current system is not fiscally sustainable

The Committee's next step was to tackle the question of whether or not the system, in its current form and given current levels of government funding, was sustainable. In Volume Five, the Committee defined a fiscally sustainable health care system as one on which Canadians could rely both today and in the future, given governments' predicted fiscal capacity and taxpayers' willingness to pay.

Two constraints must be taken into account in assessing fiscal sustainability. The first is the willingness of taxpayers to pay (consent of the governed). The second is the need, for economic development purposes, for governments to keep tax rates competitive with those in other OECD countries, and particularly with the United States.

In the Committee's view, long-term fiscal sustainability depends on the ratio of public expenditures on health care to other government spending. If this ratio becomes too large it may indicate that spending on health care is crowding out other necessary government spending.

The Committee recognizes that sustainability can also be considered in terms of the total share of the Gross Domestic Product (GDP) that is devoted to health care, whether paid through the public purse or privately. However, what that share should be is impossible to say without thorough analysis of the benefits Canadians derive from health care. Conducting such a cost-benefit analysis is precluded at present by the system's lack of the capacity to capture, record, share, and otherwise manage health information. So the best the Committee can do is observe that Canada's spending

Regardless of how it is expressed, there is only one source of funding for health care– the Canadian public – and it has been shown conclusively that the most cost-effective way of funding health care services is by using a single (in our case, publicly administered or governmental) insurer/payer model.

on health care, expressed as a share of GDP, is roughly comparable to that of other developed countries apart from the United States, where it is clearly much higher than in any other industrialized country.

The Committee is keenly aware that shifting more of the cost to individual patients and their families via private payments, the facile "solution" recommended by many, is really nothing more than an expensive way of relieving or, at the least, diminishing governments' problem. Regardless of how it is expressed (as a share of GDP, share of government spending, etc.), there is only one source of funding for health care – the Canadian public – and it has been shown conclusively that the most cost-effective way of funding health care is by using a single (in our case, publicly administered or governmental) insurer/payer model.

The Committee believes strongly that Canada should continue to adhere to this most efficient and effective model of universal health care insurance, and it is clear to the Committee that Canadians believe this too. Therefore, in formulating its recommendations, the Committee has not concentrated on measures of funding related to GDP. Instead, it has sought to assess how much public spending is necessary to sustain Medicare and, in particular, how much is needed to accomplish the changes that are essential if this highly popular and largely publicly funded program is to meet the needs of Canadians into the twenty-first century.

During the Committee's cross-country hearings, a wide range of witnesses, including health care managers, providers and consumers, expressed deep concern about rising health care costs and their impacts both on governments' budgets and on patient care. Based on this testimony as well as on numerous reports, the Committee has concluded that rising costs strongly indicate that Canada's publicly funded health care system, as it is currently organized and operated, is not fiscally sustainable given current funding levels.

The lack of sustainability is already manifest in the fact that the system does not currently have sufficient resources to respond to all the demands that are placed upon it. In particular, timely access to quality health services is increasingly not the norm. The Committee is aware that no system providing services that are perceived to be "free" can ever fully meet the demands placed on it, and that at present we are unable to discriminate between the demand and the genuine need for timely access to health services of all kinds. Nonetheless, the widespread perception of deterioration in the quality of service available to Canadians highlights the fact that Canadians must decide what future course of action they want their governments to take. The Committee stressed that there are three basic options from which the Canadian public must choose:

The Committee has concluded that rising costs strongly indicate that Canada's publicly funded health care system, as it is currently organized and operated, is not fiscally sustainable given current funding levels.

- Growing waiting lists as a result of increased rationing of publicly funded health services;
- Increasing government revenue;
- Making some services available more quickly to those who can afford to pay privately for them by allowing the development of a parallel privately funded

tier of health services, supplementary to the publicly funded system maintained for all other Canadians.[6]

As will be evident in the remainder of this report, the Committee fervently hopes that Canadians will agree with the Committee that the second option is the most desirable choice. Having unanimously reached this conclusion, the Committee has departed from usual practice in parliamentary committee reports by specifying in some detail how much additional public money is required to ensure the long-term fiscal sustainability of the health care system, recommending where this new money should be spent, and recommending how the increased government revenue could be raised.

The Committee has concluded that an additional $5 billion is needed annually to reform and renew the health care system. This is the estimated annual cost of implementing the Committee's recommendations. The Committee also stresses, however, that unless changes are made to the structure and functioning of the system, no amount of new money will make the current system sustainable over the long term. This $5 billion in new federal money must be used to buy change, to reform and renew the system.

Unless changes are made to the structure and functioning of the system, no amount of new money will make the current system sustainable over the long term. This $5 billion in new federal money must be used to buy change, to reform and renew the system.

1.1.4 A national health care guarantee is critical to successful reform

In general, the principle that the Committee has followed in working out its vision for reform of the system has been that incentives for all participants must be introduced in the publicly funded hospital and doctor system – providers, institutions, governments and patients – to deliver, manage and use health care more efficiently and effectively. In particular, although it does not stand entirely on its own, one element that is key to the successful reform of the system is what the Committee has called the health care guarantee.

This recommendation, described in detail in Chapter Six, is designed to address the problem of growing waiting times for access to health services by requiring governments to meet reasonable standards, by ensuring patients have access to services in their own jurisdiction, elsewhere in Canada or, if necessary, in another country. Meeting reasonable patient service standards is an essential part of the health care contract between Canadians and their governments. The Committee believes that by judiciously investing the new money and legislatively enshrining the principle of the health care guarantee, it will be possible to restore the Canadians' confidence that their governments will spend their tax dollars in ways that reinforce the publicly funded health care system and ensure that the system provides access to medically necessary services when and where they are needed.

In presenting its proposals, the Committee also believes that it was important to acknowledge that its preferred option for raising new money, and its plan on how to spend it, including implementing the health care guarantee, are not the only options available. If, after public discussion, governments decide that they are not willing to pay more to fund hospital and doctor services, or if the insurer (government) decides not to implement the health care guarantee, then the result would be the continued (and probably increased) rationing of services and lengthening of waiting times.

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[6] Note that the "delisting" of services means requiring Canadians to pay privately for specific services that once were paid for under the publicly administered and funded health insurance program (Medicare).

Moreover, as the Committee points out in Chapter Five below, allowing waiting times to grow longer - that is, failing to implement the health care guarantee - could have significant additional consequences. Such failure is highly likely to lead to the Supreme Court issuing a judgment that since timely access to needed medical service is not being provided in the publicly funded system, then government can no longer deny Canadians the right to purchase private insurance to cover the cost of paying for the provision of service elsewhere, i.e., at private health care institutions in Canada. Thus, failing to implement the health care guarantee is likely to move the Canadian health care system in the direction of introducing a second private tier of services available only to those who can afford to pay for them out-of-pocket or through supplementary private health care insurance.

When this possibility was raised in previous reports, some commentators felt that the Committee was in fact advocating greater privatization of the health care system. As this volume should make abundantly clear, that is not the case.

The Committee has worked out a detailed, concrete and realistic plan that, if implemented integrally, will lead to strengthening the publicly funded health care system in Canada and guarantee its sustainability for the foreseeable future. However, this option costs money, and the great majority of Canadians would be required to contribute additionally in taxes in order to implement the proposed plan. In the event that governments are unwilling to raise increased revenue to invest in the publicly funded health care system, it is essential that Canadians fully understand the implications of such a decision. One such implication is likely to be not only the continued deterioration of the system, but also judgments by the courts that hasten the development of a parallel private system of health care in Canada.

1.2 Improving Governance – The Need for a National Health Care Commissioner

An essential element to enable Canadians to make informed choices, now and in the future, is for the Canadian public to have access to a reliable and non-partisan assessment of the true state of the health care system. The remainder of this chapter sets out the Committee's proposal to create an institutional structure that would give Canadians such an assessment annually.

The Committee believes that it is essential to improve the governance of Canada's health care system.

It is essential to improve the governance of Canada's health care system. The question of governance (which is to say leadership) brings together a number of issues that the Committee has raised in previous volumes and that witnesses have addressed from a number of perspectives.

One thing is very clear. Canadians are tired of the endless finger-pointing and blame-shifting that have been recurring features of intergovernmental relations in the health care field. As the Honourable Monique Bégin has accurately pointed out, the current state of federal-provincial relations is dysfunctional.[7] On far too many occasions, each side seems more interested in attributing blame for the system's apparent deterioration to the other, rather than taking the lead to ensure that the health services Canadians need and deserve are there when they need them.

Fundamentally the underlying issue is one of accountability. In order to establish who is to be held accountable for the deficiencies (and also the strengths) of the health care system, the Committee has repeatedly pointed out that detailed and reliable information on the performance of the system and on health outcomes is essential. This is why the Committee has placed such importance on the development of a capacity for health information management, on putting in place a national system of electronic patient records[8] and on sustaining and expanding the health research infrastructure.[9] The Committee has drawn attention to the important contribution that the Canadian Institute for Health Information (CIHI) has already made to improving our knowledge of the state of the health care system; it is clear that this positive source of experience must be built upon.

Information must be analyzed and interpreted objectively if it is to serve as a reliable guide to evidence-based decision-making. In Volume Five, the Committee identified four fundamental elements that are necessary to create the capacity to evaluate fully and fairly the performance of the health care system and the health status of the Canadian population, as well as to hold the appropriate parties accountable:

- First, such evaluation must be conducted by a body that is independent of government. The Committee expressed its strong support for "the view of witnesses and provincial reports that the roles of the funder and provider should be separated from that of the evaluator in order to obtain independent assessment of health care system performance and outcomes."[10] Only in this way can actual and perceived conflicts of interest be avoided and the credibility of evaluation reports with the Canadian public be assured.
- Second, the Committee affirmed that "such independent evaluation should be performed at the national (not federal) level."[11] The reality of the Canadian health care system is that it is a joint responsibility of the provincial/territorial and federal governments. No body that reports exclusively to, or was created exclusively by, one level or the other would have the necessary credibility.
- Third, while the evaluation must be conducted by an independent, arms-length agency, it must be funded by government. Moreover, as we will argue below, leadership in providing the necessary financing for this initiative must

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[7] Monique Bégin, "Renewing Medicare," *Canadian Medical Association Journal*, July 9, 2002, p. 47.

[8] See Chapter 10.

[9] See Chapter 12.

[10] Vol. 5, p. 51.

[11] Ibid.

be provided by the federal government, despite the "national" (as opposed to federal) character of the evaluation organization.

- Finally, as noted above, it is essential that this undertaking build on the successes of existing organizations, such as the Canadian Institute for Health Information (CIHI) and the Canadian Council for Health Services Accreditation (CCHSA). The Committee makes specific recommendations with regard to these organizations in Chapter Ten.

The Committee believes, however, that, on their own, existing organizations are not enough. What is needed is a permanent independent body charged with reporting annually to the Canadian public on the state of the nation's health care system and on the health status of Canadians. The Committee also believes that this body should be responsible for advising the federal government, on an annual basis, on how new money raised for renewing and reforming the health care system should be allocated. Such a body must have sufficient resources at its disposal, and work with CIHI and CCHSA (and possibly others), to collect and assess the data and information it requires.

What is needed is a permanent independent body charged with reporting annually to the Canadian public on the state of the nation's health care system and on the health status of Canadians. The Committee also believes that this body should be responsible for advising the federal government, on an annual basis, on how new money raised for renewing and reforming the health care system should be allocated.

Before setting out the Committee's own proposal, we review briefly some other ideas that have been put forward in recent months that describe ways of providing the Canadian public with annual evaluation reports on the state of the health care system. In the Committee's view, the various proposals contain many useful elements, but none fully meets the Committee's requirements.

1.2.1 Canadian Medical Association (CMA)

The CMA has proposed a two-pronged approach.[12] First, it advocates the adoption of a Canadian Health Charter with three main parts: a vision statement, a section on national planning and coordination, and a section on roles, rights and responsibilities. This Charter would set the parameters for better national planning and coordination, particularly with respect to reviewing core health care services; developing national benchmarks for the timeliness and quality of health care; determining resource needs, including health human resources and information technology; and establishing national goals and targets to improve the health of Canadians.

The CMA's proposal also provides for the creation of a Canadian Health Commission, a permanent, depoliticized forum at the national level for ongoing dialogue and debate. The commission's mandate would include the following responsibilities:

- Monitor compliance with the Canadian Health Charter

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[12] See its document, *A Prescription for Sustainability*, June 2002.

- Report annually to Canadians on the performance of the health care system and the health status of the population
- Advise the Conference of Federal–Provincial–Territorial Ministers of Health on critical health-related issues.

The commission proposed by the CMA would be chaired by a Canadian Health Commissioner, who would be an officer of Parliament (similar to the Auditor General) appointed for a five-year term by consensus among the federal, provincial and territorial governments. The commission would operate at arm's length from governments, yet maintain close links with government agencies such as the Canadian Institute for Health Information and the Canadian Institutes of Health Research. Its deliberations would be made public, and its composition would not be constituency-based but would reflect a broad range of perspectives and expertise.

1.2.2 Colleen Flood and Sujit Choudry

In a paper prepared for the Romanow Commission,[13] Professors Colleen Flood and Sujit Choudry of the University of Toronto argue that there is a real need for a non-partisan national body, protected from day-to-day politics, with a longer-term view than is possible for an elected government. They propose the creation of a Medicare Commission that would be an expert, independent body, appointed jointly by provincial and federal governments, but funded by the federal government.

The role of this Medicare Commission would include:

- determining specific performance indicators to help provinces achieve national standards set out in the *Canada Health Act*;
- publishing (in conjunction with the Canadian Institute for Health Information) annual reports on the performance of provincial health insurance systems;
- providing financial assistance to those provinces that undertake to implement the processes or programs identified by the Commission.

Funding for the commission would be separate from federal transfers for health care. It would consist of new federal money, a consolidation of all one-off payment initiatives in the health care area currently undertaken by the federal government (for example, in primary care and other areas).

One possible method Flood and Choudry describe for composing the commission is for each province to appoint 1 commissioner and the federal government to appoint 5, for a total of 15 full-time commissioners, who would then select a chief commissioner from among themselves. All decisions would require a two-thirds majority, meaning that federal commissioners would require support from a majority of provincial commissioners for any decision.[14] The commission that they propose would have an expert staff of health service researchers and would make its reports publicly available, including specific findings on the compliance of provincial health care plans with national standards.

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[13] Colleen M. Flood and Sujit Choudry, *Strengthening the Foundations: Modernizing the Canada Health Act*, Discussion Paper No.13, released by the Commission on the Future of Health Care, August 2002.

1.2.3 Tom Kent

Tom Kent was a senior federal public servant at the time Medicare was created, and is often referred to as a father of Medicare. Her has suggested that Ottawa and the provinces appoint, by consensus, an advisory council with a wide range of expertise.[15] The purpose is neither to replace provincial management of provincial programs nor to impair federal accountability for the principles of Medicare. Rather, the council is conceived as a collaborative mechanism that would be a bridge between the two levels of government, thereby bringing political reality into harmony with the way most Canadians already see Medicare, namely, as a joint responsibility within our federal system.

Kent's council would be funded jointly by the federal and provincial governments. It would employ an executive director and staff, who would be neither federal nor provincial officials. It would report to a joint committee of health ministers, for which it would conduct investigations and make recommendations over the whole range of medicare principles and practices.

The proposed council would provide a focus for collaboration that would facilitate innovation and efficiencies, as well as provide a forum for broader consultation on health policy. Administratively, it could be used to supervise the implementation of agreements on such matters as electronic health records, health care information, a national drug formulary, bulk purchasing, facility sharing, etc. Importantly, Kent argues that the agency could foster public accountability by preparing regular reports for the ministerial committee to issue.

1.2.4 Duane Adams

In his review of proposals for improving the governance of the Canadian health care system,[16] the late Professor Duane Adams, founding director of the Saskatchewan Institute of Public Policy, noted that "there may be benefits to the federation and the Canadian people if an external-to-government health oversight body were added to the Canadian health system's governance mechanism." He points out that even though most governments are very sceptical and leery of these "arm's-length" agencies because they have the potential to "deplete the unilateral power of governments," "an independent oversight body should be seen as one option in a range of possibilities, to enhance public participation, transparency, public accountability, and public confidence."

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[14] It should be noted that is formula would appear to allow the provincial commissioners to band together to make decisions that were unanimously opposed by the federal commissioners.

[15] Tom Kent, *Medicare: It's Decision Time*, The Caledon Institute of Social Policy, 2002.

[16] Duane Adams, "Conclusions: proposals for advancing federalism, democracy and governance of the Canadian health system," in *Federalism, Democracy and Health Policy in Canada*, ed. Duane Adams, McGill-Queen's University Press, 2002.

One option presented by Adams was a Canadian Health Council that would have an element of public participation and employ a small number of permanent staff. Its functions might include:

- monitoring the Canadian health system, and regularly advising governments and Canadians about its findings;
- appraising specific Canada-wide health issues of immediate public concern and developing practical options to address them;
- serving as a neutral fact-finding body for intergovernmental disputes concerning the *Canada Health Act* and other issues referred to it by governments, and serving upon request by governments as a facilitator/mediator in the dispute resolution process;
- providing an annual report to the public about the performance of the health system and emerging issues;
- taking some defined responsibility to test innovative health service delivery and management concepts of national significance;
- perhaps serving as one possible vehicle to assemble and disseminate best practice experiences from the Regional Health Authorities across Canada.

This Council would be part of a network of bodies that would contribute to improving the governance of the health care system. It could include representatives from the Canada Health Services Research Foundation, the Canadian Institutes of Health Research, the Canadian Institute for Health Information, and the Canadian Council on Health Services Accreditation.

1.2.5 Lawrence Nestman

In his testimony before the Committee,[17] Professor Lawrence Nestman from the School of Health Services Administration at Dalhousie University drew on the experience of the Dominion Council of Health in the 1960s. This Council was a permanent body where deputies and ministers liaised with a number of health commissions at both the federal and provincial levels. It had a permanent secretariat staffed by highly skilled people who related to full-time public servants in provincial health departments. This arrangement enabled greater continuity in policy making and more coordination of federal-provincial relationships than is possible today. Professor Nestman therefore proposed "the concept of a revised Dominion Council of Health for the federal government as well as some kind of permanent infrastructure in the provinces [that] would improve federal-provincial relations and provide continuity as well as some arm's length input for the day-to-day operations."[18]

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[17] May 9, 2002. (*Proceedings*, Issue 55)

[18] *Ibid.*, 55:13.

1.3 The Committee's Proposal

The Committee believes that the mandate of the independent evaluation body should be to publish an annual report on the state of the health care system, and on the health status of Canadians, as well as whatever other reports it feels are needed to spur improvements in health outcomes and the delivery of health care in Canada.

While each of the above proposals contains interesting elements and valuable suggestions, none meets fully the Committee's view of what is required. Moreover, they all tend to assign much broader mandates to the bodies they recommend than the Committee feels is appropriate at this time. The Committee agrees with the many witnesses who stressed the importance of taking measures to "depoliticize" the management of the health care system. However, the Committee feels that this will be a long-term process, and that it is important to begin with the evaluation function only. Therefore, the Committee believes that the mandate of the independent evaluation body should be to publish an annual report on the state of the health care system, and on the health status of Canadians, as well as whatever other reports it feels are needed to spur improvements in health outcomes and the delivery of health care in Canada. The Committee believes it would also be appropriate for this independent evaluation body to advise the federal government on how new money raised to reform and renew the health care system should be spent (see Chapter Fourteen).

To legitimate such reports with all levels of government, and yet to ensure their independent production and thereby their credibility with the Canadian public, the Committee recommends that the following structures and procedures be put in place.

First, a new federal/provincial/territorial (F/P/T) body is required. This committee must be structured so that neither the federal nor the provincial/territorial representatives are able to dominate it. It is therefore proposed that the committee be composed of one provincial/territorial representative from each of the five major regions of the country (Atlantic, Quebec, Ontario, Prairies, British Columbia), and five representatives from the federal government. The provincial/territorial representatives would be selected in a manner that remains to be determined.[19]

This F/P/T committee, after consulting with a broad range of health care stakeholders, would appoint a National Health Care Commissioner. It would also select the members of a National Health Care Council that the Commissioner would chair from among those nominated by the Commissioner. In making nominations to the Council, the Commissioner would have the responsibility of ensuring that the membership of the Council is balanced, and that the public at large is represented. Councillors should be appointed on the basis of their ability to take a global view of the health care system, and not as representatives of specific health care constituencies.

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[19] This form of provincial/territorial representation is already used in the composition of the Board of Directors of Canadian Blood Services, whose mission is to manage the blood and blood products supply for Canadians in all provinces except Quebec. Four of its Directors represent one of each of the following regions: (a) British Columbia and Yukon, (b) Prairies, Northwest Territories and Nunavut, (c) Ontario, and (d) Atlantic.

So that the selection of the Commissioner and the members of the Council not be dominated by either the federal or provincial/territorial representatives, a two-thirds majority would be required for all appointments. With 10 members on the F/P/T committee, seven votes would be required to confirm all appointments, meaning that neither the federal nor the provincial/territorial representatives could succeed on their own. This procedure further guarantees that the members of the Council would be independent of government (having being nominated by the Commissioner), yet possessing sufficient legitimacy to lend weight to their report (having been appointed by the F/P/T committee).

The Commissioner should be appointed for a five-year term, with the possibility of a single renewal. Council members should be appointed for three-year terms, with the possibility of a single renewal. Half the council would be up for renewal every three years. Eight is a reasonable number of councillors, a total of nine including the Commissioner. They should be adequately compensated for their work with the Council, but would not be full-time employees. A full-time staff would report to the Commissioner.

The Council would have ultimate responsibility for the publication of the annual report and would present it to each Ministry of Health with a request that it be tabled with all federal, provincial and territorial legislatures. The Committee recommends that all F/P/T Ministers of Health respond formally within six months to the annual report that the National Health Care Council would produce. While the Committee recognizes that it would not be possible to require legally that the F/P/T Ministers of Health respond to the annual report, it believes that the Ministers should accept responsibility for issuing a formal response within a six-month period. This would be much like the current requirement for the federal government to respond within a specified time frame to the recommendations made by House of Commons committees. It would ensure that serious consideration is given to the Council's annual report. Furthermore, since the Council's annual report would simultaneously be made public, there would be additional public pressure on all governments to consider carefully and respond to the report and its recommendations.

The Committee believes that the federal government should show leadership by providing the funding for the work of the Commissioner and the Council. This funding should come from the new money that the Committee recommends be raised in Chapter Fifteen.

Should the Commissioner and the Council see the need to broaden the scope of their work, or should the federal and provincial governments initiate such expansion, the provision of any additional funding should be the responsibility of governments on a 50/50 federal/provincial basis, and not necessarily fall exclusively on the shoulders of the federal government.

The Commissioner would be responsible for hiring the necessary professional and technical staff to carry out the Council's mandate. In this regard, however, the Commissioner should not attempt to duplicate the work of existing organizations. Rather, the Commissioner would cooperate with CIHI and CCHSA, and other concerned federal and provincial organizations, to ensure application of the most efficient methods possible to gather the data and information required to produce the annual report (see Chapter Ten).

The Committee believes that, structured in this way, the National Health Care Council chaired by an independent Health Care Commissioner meets the four conditions described earlier:

- The process has a national and not purely federal character;
- The Commissioner and the Council are independent of government, yet have the legitimacy of having been appointed by government representatives;
- The production of an annual report is funded by government;
- The work of the Commissioner and the Council builds on existing organizations.

In summary, then, the Committee recommends that:

New federal/provincial/territorial committee made up of five provincial/territorial and five federal representatives be struck. Its mandate would be to appoint a National Health Care Commissioner and the other eight members of a National Health Care Council from among the Commissioner's nominees;

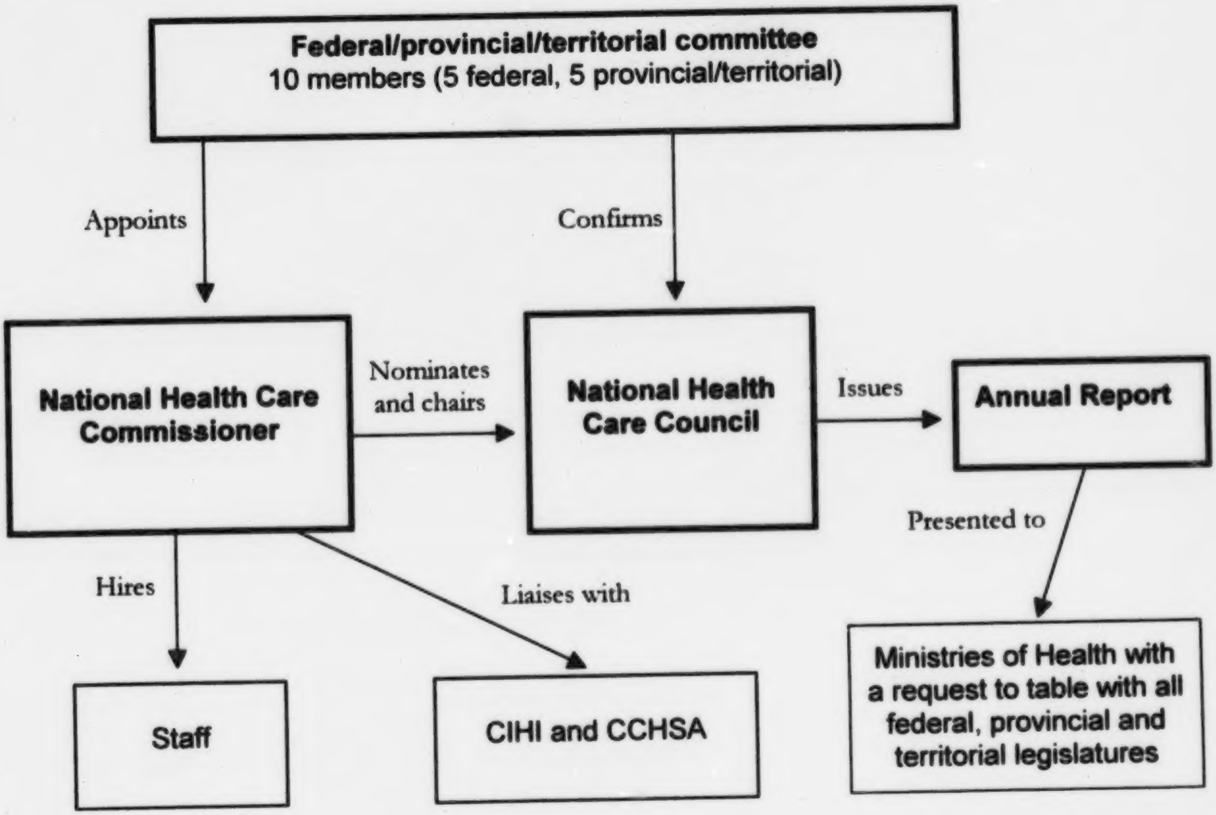
The National Health Care Commissioner be charged with the following responsibilities:

- **To put nominations for members to a National Health Care Council before the F/P/T committee and to chair the Council once the nominees have been ratified;**
- **To oversee the production of an annual report on the state of the health care system and the health status of Canadians. The report would include findings and recommendations on improving health care delivery and health outcomes in Canada, as well as on how the federal government should allocate new money raised to reform and renew the health care system;**
- **To work with the National Health Care Council to advise the federal government on how it should allocate new money raised to reform and renew the health care system in the ways recommended in this report;**
- **To hire such staff as is necessary to accomplish this objective and to work closely with existing**

independent bodies to minimize duplication of functions.

The federal government provide $10 million annually for the work of the National Health Care Commissioner and the National Health Care Council that relates to producing an annual report on the state of the health care system and the health status of Canadians, and to advising the federal government on the allocation of new money raised to reform and renew the health care system.

Figure 1.1
Proposal For A National Health Care Commissioner
and A National Health Care Council


Federal/provincial/territorial committee
10 members (5 federal, 5 provincial/territorial)
Appoints
Confirms
National Health Care Commissioner
Nominates and chairs
National Health Care Council
Issues
Annual Report
Presented to
Hires
Liaises with
Staff
CIHI and CCHSA
Ministries of Health with a request to table with all federal, provincial and territorial legislatures

Part II: Efficiency Measures

CHAPTER TWO

HOSPITAL RESTRUCTURING AND FUNDING IN CANADA

With few exceptions, Canadian hospitals exist as not-for-profit entities.[20] Ownership usually resides with community-based not-for-profit corporations, religious organizations, or (rarely) with municipal governments or universities. Apart from psychiatric hospitals, provincial/territorial governments rarely own hospitals. In all cases, however, the vast majority of hospital revenues come from a single funder – the provincial/territorial department of health.

TABLE 2.1
HOSPITAL SPENDING IN CANADA, 1986 TO 2001
(AS A PERCENTAGE OF TOTAL HEALTH CARE EXPENDITURES)

	1986	1991	1996	1998	2001
British Columbia	37.0	34.1	30.4	29.6	28.1
Alberta	39.8	39.1	30.1	29.8	29.9
Saskatchewan	34.3	34.0	26.7	26.3	28.2
Manitoba	39.3	37.8	33.2	32.1	30.0
Ontario	37.9	36.0	33.2	30.6	29.6
Quebec	46.9	44.4	38.0	38.4	36.4
New Brunswick	42.6	40.9	39.1	36.8	38.1
Nova Scotia	47.0	46.1	38.7	40.5	37.8
Prince Edward Island	38.6	38.9	36.1	35.6	34.7
Newfoundland	46.2	47.8	43.4	41.4	39.3
Average Canada	**41.0**	**39.9**	**34.9**	**34.1**	**33.2**

Source: Calculations done by the Economics Division, Parliamentary Research Branch, Library of Parliament. Based on data from the Canadian Institute for Health Information, "Health Expenditure by Use of Funds, By Source of Finance, Province/Territory 1975-2001," *National Health Expenditure Database (NHEX).*

Note : Hospitals include all hospitals approved by provincial governments providing acute care, extended and chronic care, rehabilitation and convalescent care, and psychiatric care, as well as nursing stations and outpost hospitals. "Average Canada" represents the unweighted average for the provinces.

Provincial governments spent some $32.1 billion on hospitals in 2001.[21] This represented almost a third of total provincial/territorial government expenditures on health care. Hospitals represent the largest category of health care spending in Canada. However, their share has been declining significantly. For example, in 1986, spending on hospitals, as a percentage of total health care spending, averaged roughly 41% among the provinces. By 2001, this share fell to an average of approximately 33% (see Table 2.1). This sharp decline is due primarily to changes in knowledge and technology that increasingly permit diagnoses and therapies to be provided safely out-of-hospital and to consequent hospital downsizing and restructuring across the country. As the proportion of health care spending devoted to hospital care has decreased, that allocated to home care and other forms of community-based care has increased.

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[20] Only 5% of hospitals in Canada are private for-profit institutions.

[21] Canadian Institute for Health Information, "Health Expenditure by Use of Funds, By Source of Finance, Province/Territory 1975-2001," *National Health Expenditure Database (NHEX)* (http://www.cihi.ca/dispPage.jsp?cw_page=statistics_results_source_nhex_e).

In Volume Five, the Committee enunciated a number of principles regarding the funding of hospitals. Principle One stated that Canada should keep its current single funder/insurer model for financing hospital services, and that this single insurer should be government.[22] Principle Eight stated that the current methods used for remunerating Canadian hospitals should be replaced by service-based funding.[23]

The Committee believes that service-based funding will achieve a number of important objectives, including: measuring in an appropriate manner the cost of specific hospital services; improving overall hospital efficiency; enabling the public to compare hospitals based on their performance; enhancing hospital accountability; fostering competition among hospitals; reducing waiting lists and encouraging the further development of centres of specialization.

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The Committee also acknowledged in Volume Five that modifications to a pure service-based funding model may be necessary for teaching hospitals and possibly for very small community hospitals. We also believe that the federal government should consider contributing to the capital investment needs of Canadian hospitals, particularly academic health science centres (or teaching hospitals) and hospitals located in areas of exceptionally high population growth.

This chapter provides information on hospital funding in Canada, summarizes the testimony received on this issue and reiterates the Committee's view of the merits of service-based funding. The chapter is divided into seven sections. Section 2.1 reviews and compares current methods used for funding hospitals in Canada. Section 2.2 describes service-based funding and reviews relevant international experience. Section 2.3 details the Committee's rationale for recommending service-based funding for hospitals in Canada and highlights the various challenges posed by this mode of hospital remuneration. Sections 2.4 and 2.5 examine in detail the particular issues raised with respect to academic health science centres and small and rural community hospitals. Section 2.6 examines the issue of capital needs of Canadian hospitals. Finally, Section 2.7 provides the Committee's view on public versus private (for-profit and not-for-profit) hospitals.

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[22] Volume Five, pp. 23-25.

[23] Volume Five, pp. 36-39.

2.1 Funding Methods for Hospitals in Canada: Advantages and Disadvantages[24]

Provincial/territorial governments use a variety of approaches to finance hospitals. There is no one model that can accurately portray the financing of hospitals in Canada. Furthermore, provinces/territories do not use a single method to distribute funds to their hospitals. Most rely on a primary funding approach to allocate the majority of funds and a number of secondary methods to apportion lesser amounts.

Methods of hospital funding used in Canada, both primary and secondary, include: line-by-line, ministerial discretion, population-based, global budget, policy-based, facility-based, project-based and service-based. As Table 2.2 shows, provincial governments rely on seven of these methods to finance the operating costs of hospitals. Funds for capital purposes (to pay for hospital construction, major building renovations, and high-cost equipment purchases) are provided in all provinces using a project-based method.

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[24] Unless otherwise indicated, the information provided in this section is based on the following documents:
Sheila Block, *The Ontario Alternative Budget 2002 – Health Spending in Ontario: Bleeding our Hospitals*, Canadian Centre for Policy Alternatives (Ontario), May 2002 (www.policyalternatives.ca).
Comité sur la réévaluation du mode de budgétisation des centres hospitaliers de soins généraux et spécialisés (Comité Bédard), *La budgétisation et la performance financière des centres hospitaliers*, Santé et services sociaux, Government of Quebec, 2002 (www.msss.gouv.qc.ca).
Jeffrey C. Lozon and Robert M. Fox, "Academic Health Sciences Centres Laid Bare," *Healthcare Papers*, Vol. 2, No. 3, 2002, pp. 10-36 (http://www.longwoods.com/hp/2-3academic/index.html).
Les Vertesi, *Broken Promises: Why Canadian Medicare is in Trouble and What Can be Done to Save It*, Document tabled with the Standing Senate Committee on Social Affairs, Science and Technology, 2001.
Ian McKillop, George H. Pink and Lina M. Johnson, *The Financial Management of Acute Care in Canada -A Review of Funding, Performance Monitoring and Reporting Practices*, Canadian Institute for Health Information, March 2001 (http://www.cihi.ca/dispPage.jsp?cw_page=GR_32_E).
Danish Ministry of Health, *Hospital Funding and Casemix*, September 1999 (http://www.sum.dk/publika/eng/hosp_casemix/).
Nizar Ladak, *Understanding How Ontario Hospitals are Funded: An Introduction*, Joint Policy and Planning Committee, Ontario, March 1998 (www.jppc.org).

TABLE 2.2
HOSPITALS IN CANADA BY PROVINCE, 2000

Province	Number of Hospitals	Number of Beds per 1,000	Primary Funding Approach	Secondary Funding Approach
BC	80	3.7	Line-by-Line and Pop.-Based	Policy-Based
ALTA	115	3.5	Population-Based	Policy-Based
SASK	71	3.7	Population-Based	None
MAN	79	4.1	Ministerial Discretion	None
ONT	163	2.3	Global Budget	Multiple[1]
QC	95	3.0	Global Budget	Multiple[2]
NB	30	5.3	Line-by-Line and Pop.-Based	None
NS	35	3.3	Ministerial Discretion	None
PEI	7	3.4	Ministerial Discretion	None
NFLD	33	4.6	Ministerial Discretion	None

Source: McKillop *et al.* (2001), Table 1.1 (p. 9), Table 3.2 (p. 46) and Table 3.5 (p. 53). Population data from Statistics Canada, CANSIM II, Table 051-0001.

(1) Policy-Based, Facility-Based, Population-Based and Service-Based.

(2) Population-Based and Policy-Based.

Note: Number of beds for Nova Scotia includes acute care only.

More specifically, two provinces (British Columbia and New Brunswick) use a line-by-line method. Four provinces (Manitoba, Prince Edward Island, Nova Scotia, Newfoundland) use a ministerial discretion method. Two provinces (Alberta and Saskatchewan) have primary operating funding approaches with a population-based method, while two others (Ontario and Quebec) use global budgets. The policy-based method is the most commonly used secondary funding approach in four provinces (British Columbia, Alberta, Ontario and Quebec). Two provinces (Ontario and Quebec) also use a population-based method in combination with the primary method.[25] At present, only Ontario uses a service-based method for financing selected hospital services.

2.1.1 Line-by-line

Line-by-line budgeting used to be the most popular method of hospital financing in Canada. This method involves negotiating amounts for specific line items (or inputs) such as in-patient nursing services or medical/surgical supplies. The total budget allocation for an individual hospital, then, is simply the sum of the line items. British Columbia and New Brunswick still rely on line-by-line budgeting (combined with a population-based method) as their primary budgeting approach.

On the positive side, line-by-line budgeting allows provincial ministries of health to link specific activities with policy objectives through direct spending. For example, a province that wishes to promote day surgery could increase the line funding available for this activity by a factor greater than that applied to the in-patient nursing line. Line-by-line funding also gives hospitals a higher degree of financial predictability than some other methods.

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[25] Although the classification of funding method may be the same for a number of jurisdictions, the way in which the method is implemented may differ.

However, this method has a number of disadvantages which have caused several provincial ministries to move away from the approach. On the one hand, the line-by-line method prevents reallocation among lines and thus reduces flexibility in managing funds. On the other hand, the approach is not related to performance and therefore does not encourage efficiency. In addition, line-by-line budgeting provides information only on the cost of inputs, not on the cost or quality of outputs. Moreover, the effort involved in scrutinizing line-by-line budget detail is significant. The most serious disadvantage, however, it that it tends to diminish the capacity of hospital boards and managers to link the hospital's activities directly with the needs of the community it serves.

2.1.2 Ministerial discretion

With this method, funding is based on decisions made by the provincial minister of health in response to specific requests by the hospital concerned. This method is used as the primary funding approach in Manitoba, Nova Scotia, Prince Edward Island and Newfoundland.

Although the ministerial discretion method is highly subjective, it offers a number of advantages. From the government's perspective, this method is extremely flexible; ministerial decisions are not constrained by formulas or other predetermined budgeting methods.

The major drawback of this funding approach is that it risks being myopic, inconsistent and overtly "political." Significant changes in funding can and do occur with a new government or a change in policy. Furthermore – and this is critical from the Committee's point of view – this method clearly lacks transparency. Witnesses told the Committee repeatedly that there is a need to depoliticize hospital financing. For example, Mark Rochon of the Ontario Hospital Association stated that:

> *We need to consider and promote mechanisms that (…) insulate, as much as we can and are able to do, decisions concerning the provision of health services from politics.*[26]

2.1.3 Population-based

Population-based methods use demographic information such as age, gender, socio-economic status and mortality rates to forecast the demand for hospital services. Matching the predicted demand for certain health services with the estimated cost of providing these services yields a spending forecast for individual hospitals (or for regional health authorities). At present, Alberta and Saskatchewan use population-based funding as their primary methods, while British Columbia and New Brunswick use it in combination with a line-by-line budget approach. Newfoundland, Nova Scotia, Ontario and Quebec are currently considering adopting a population-based approach as their primary funding method.

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[26] Mark Rochon, Ontario Hospital Association (56:42).

The Committee learned that a population-based method, employing formulae strictly to distribute funds, can be objective, equitable and accommodate the needs of particular regions and hospitals. In addition, the CEO of the Calgary Health Region, Jack Davis, told the Committee that in Alberta, the population funding system had helped to depoliticize the allocation of resources.[27]

However, ensuring that a population-based formula accounts for all the factors that affect the health care a population requires is complex and difficult to implement. Such a method requires good information systems that are resource-intensive (equipment, databases, staff).

This budgeting method may become too complex and create a lack of transparency with users unable to understand or predict how funding amounts have been determined. According to Les Vertesi, Chief of the Department of Emergency Medicine at the Royal Columbian Hospital (Vancouver), a population-based funding model can only provide an estimate of where health care resources will be needed; it will not provide incentives for better service.[28]

2.1.4 Global budget

Global budget methods adjust previous spending (such as last year's base allocation) to derive a proposed funding level for the upcoming year. The focus is on the total hospital budget rather than on individual service activities or cost centres within the hospital. Adjustments can be made to the base amount using a multiplier (such as the rate of inflation) or a lump-sum amount to establish the funding level for future periods. Quebec introduced global budgets as its primary funding approach in 1994, while Ontario has used this method since 1969.[29]

The Committee learned that because hospital activities change little from year to year, provincial governments find it much easier to simply repeat the previous year's allotment with an adjustment for inflation or population growth. Therefore, global budgets are straightforward to calculate for the provincial government and predictable for the hospital. Dr. Vertesi explained that global budgets gained popularity mainly because they allowed governments to control costs while at the same time granting hospital management a great deal of discretion in the allocation of funds among a hospital's various operations.[30]

Similarly, in its brief, the Canadian Healthcare Association made the argument that global budgets encourage efficiency by permitting hospitals to distribute savings from one area of operation to another area of need. The Association further argued that global funding allows the delivery of comprehensive, integrated health care, which, in the long run, can reduce overall health care costs.[31]

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[27] Jack Davis, Calgary Health Region (53:40).
[28] Les Vertesi (2001), *op. cit.*, p. 117.
[29] Barer, M.L. (1995), "Hospital Financing in Canada," Chapter Two in *Hospital Funding in Seven Countries*, Office of Technology Assessment: U.S. Congress, p. 23.
(http://www.wws.princeton.edu/cgi-bin/byteserv.prl/~ota/disk1/1995/9525/952504.PDF)
[30] Les Vertesi (2001), *op. cit.*, p. 31.

Despite these advantages, many witnesses expressed the view that global budgets have numerous drawbacks and that, according to Dr. Vertesi, this mode of hospital remuneration is "an archaic funding model."[32] First, the Committee was told that funding under a global budget is unrelated to the services that are actually provided by a hospital. Second, we also heard that any inequities that exist between hospitals are perpetuated through global budgets. Third, witnesses stressed that global budgets do not encourage hospitals to improve performance; indeed, they can perpetuate and reward inefficient hospitals and penalize more efficient ones. Fourth, the Committee learned that funding under a global budget cannot accommodate changes in population and management structures. Last, but perhaps most important, witnesses raised the fact that there is a progressive and permanent loss of information under global budgets about what specific hospital services cost; hospitals have no incentive to measure such unit costs.

Overall, the majority of witnesses agreed that after years of global budgets in a number of provinces, no one knows how much anything costs any more and that, as a result, it is difficult to know even approximately what the public is getting for its spending on hospitals. The Committee believes that the lack of costing data with respect to hospital services is inconsistent with our vision of what a twenty-first century service sector ought to be: that is, a sector capable of providing timely and high-quality care on the basis of strong evidence-based decision making, and held accountable as a result of governments (and the public) knowing which services in which hospitals are provided efficiently, and which are not.

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2.1.5 Policy-based

Under this method, funding is distributed to achieve specific policy objectives. Unlike the ministerial discretion approach, where the health department (or minister) responds to individual requests for funding, a funding decision under the policy-based method has an equal effect on all institutions that provide the services encouraged by a particular policy (such as a 48-hour postpartum stay in a family birthing unit).

From the government's perspective, this method provides the department with a mechanism to ensure that policy initiatives are embraced by hospitals. Nonetheless, many hospitals consider that this method of funding interferes with their operations and provision of services. Furthermore, it is not a very predictable source of funding, since funding patterns will change if governments or policies change.

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[31] Canadian Healthcare Association, Brief to the Committee, June 2002, p. 6.

[32] Les Vertesi (53:44).

2.1.6 Facility-based

Facility-based methods use characteristics of the hospital, such as size, amount of teaching activity, occupancy and distance from nearest tertiary facility (specialized care centres, etc.), to estimate operating costs. This approach recognizes that the structure of different hospitals can influence the cost of providing identical services.

Funding under a facility-based approach attempts to accommodate differences in organizational structure (rural versus urban hospitals, teaching versus community hospitals, and so on). It is, however, insufficiently responsive to changes in demographics or in disease patterns. Furthermore, facility-based funding does not reward utilization efficiencies.

2.1.7 Project-based

Project-based methods distribute funds in response to proposals for a one-time need. This method is often used by provincial/territorial governments to finance significant capital expenditures (such as building a new hospital wing). Project based budgeting is distinct from policy-based budgeting: the former method directs funding to an individual hospital for a specific identified need, while the latter apportions a pool of money among various hospital to effect policy initiated by government.

2.1.8 Service-based

Service-based funding for hospital services is often referred to as a "case-mix-based approach" in Canadian and international literature; both concepts are used interchangeably in this chapter.

Case-mix-based or service-based methods use the volume and type of cases treated (such volume of dialysis, bypass surgery, knee or hip replacement, etc.) by a hospital to determine funding. More precisely, case-mix measurement requires two essential components: 1) the classification of patients into clinically meaningful groups that use similar levels of hospital resources, and 2) the attachment of a weight to each group to estimate relative resource use. These weights usually reflect the average cost of treating the patients in each group; they are used to construct individual hospital case-mix indices that measure average patient resource intensity, usually relative to a national norm. A higher case-mix index indicates greater patient resource intensity. Therefore, under service-based funding, hospitals are reimbursed for the episode of care for which the patient is admitted and based on the type of service or procedure performed on the patient.

The current literature on case-mix-based approaches seems to suggest that such methods fund hospitals more equitably than other methods. A particularly attractive characteristic of case-mix-based approaches is that they encourage efficiency and performance. International evidence indicates a clear trend toward such approaches.

Ontario used a service-based funding method in the summer of 2001 to distribute $95 million of additional lump-sum funding to hospitals. The new funding methodology was developed by the Joint Policy and Planning Committee (JPPC). The JPPC recommended that this methodology be implemented gradually over the next three years and that its impact be monitored.[33]

2.2 Service-Based Funding: Review of International Experience

2.2.1 United States

As in Canada, hospitals represent the single largest category of health care spending in the United States. The organization of the American hospital sector is, however, one of the most complex in the world with a heterogeneous collection of hospitals, payers and funding methods.[34] In 1998, 28% of hospitals were classified as public (state or local government) hospitals, 58% as private, not-for-profit hospitals and 14% as private for-profit hospitals.[35] Financing for hospital services comes from a number of private insurers, out-of-pocket costs and from the Medicaid and Medicare programs.[36]

In 1983, the Health Care Financing Administration (now Centers for Medicare and Medicaid Services) introduced the Prospective Payment System (PPS), under which hospitals were paid according to a case-mix-based approach, the Diagnostic Related Groups (DRGs) classification. Eighty-one percent of hospitals are now remunerated using the DRG system.[37] The rates that are paid to hospitals are based on the average costs of a specific treatment and are independent of a patient's actual length of stay in hospital.[38] These rates may be adjusted upward if a hospital services a population with a disproportionately high number of low-income residents. While most hospitals use a common rate-setting methodology, actual rates are determined by each individual state. All rates are reviewed annually by the United States Congress. Private insurance companies and managed care plans are free to set their own hospital rates according to state guidelines, if any.

The wide variety of payers and payment rates under the DRG classification has led hospitals to develop detailed information systems that are equated with high administrative costs. Nonetheless, DRGs allow for the comparison of resource use across American hospitals and, as a result, encourage competition among institutions. Appearing before the Committee, Dr. Duncan Sinclair, former chair of the Ontario Health Services Restructuring Commission, said:

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[33] Ontario Joint Policy and Planning Committee, *Hospital Funding Report Using 2000/01 Data*, Reference Document No. RD 9-12, October 2001 (www.jppc.org).

[34] Laschober, Mary, and James Vertrees, "Hospital Financing in the United States," Chapter Eight in *Hospital Funding in Seven Countries*, Office of Technology Assessment; U.S. Congress, 1995, p. 136. (http://www.wws.princeton.edu/cgi-bin/byteserv.prl/~ota/disk1/1995/9525/952510.PDF)

[35] *Comité Bédard* (2001), p. 38.

[36] Medicaid is a joint federal-state program that provides health care insurance for low-income Americans. Medicare is a federal health care insurance program responsible for covering individuals 65 years old and over. Together, these two programs cover roughly 30% of the American population.

[37] *Comité Bédard* (2001), p. 38.

[38] Two lists of rates are used, based on whether a hospital is located in an urban area (defined as more than a million inhabitants) or a non-urban area.

> *it is not a bad idea to have hospitals paid basically on the basis of DRGs and the volume related to those, much along the line of what is common in the United States. That is a very good idea.*[39]

The literature suggests that "DRG creep" (or "up-coding") has become a common problem among American hospitals. This problem occurs when hospitals attempt to maximize their reimbursements by choosing diagnostic codes that result in higher payments that may not be medically justified.[40] However, the Committee was also told that close auditing of the DRG category into which a patient is put has substantially reduced the amount of DRG creep, particularly since there have been some high-profile cases when health care firms and their executives have been convicted of fraud associated with this practice.

2.2.2 United Kingdom

Britain's major reform of the National Health Service (NHS) came in 1991 when it introduced internal competition by separating the "purchaser" from the "provider" of health services. Hospitals were set up as independent "trusts" and were expected to negotiate contracts with purchasers – Fundholding doctors and District Health Authorities. To accommodate this model, case-mix systems were introduced as the method of payment. The NHS reforms were severely criticized because they led to significant increases in administrative costs.

More reforms took place in 1997, substituting cooperation for the previous emphasis on competition. But hospital funding has remained the same. Currently, District Health Authorities are financed based on their populations. Hospitals are then funded by the District Health Authorities based on case-mix methods.

2.2.3 France

The hospital sector in France is split between public hospitals, which handle roughly 75% of hospital activity, and private hospitals, responsible for the remaining 25%. The two types of hospitals are remunerated differently. All public hospitals receive global operating budgets that are based on the previous year's amount and increased annually by a rate determined by government. Private hospitals, on the other hand, are paid through a combination of a per diem rate for the number of cases handled.

France is currently considering a move towards case-mix financing for public hospitals. For almost 20 years, the French hospital sector has been developing DRG-style case-mix information systems. In 1996, the *Programme de Médicalisation du Système d'Information* (PMSI) released for the first time reliable patient data, designed specifically for French conditions. When used to measure the performance of French hospitals, the PMSI data revealed significant disparities in performance and capabilities among institutions and regions. French analysts feel that the present system of global budgets perpetuates these disparities.

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[39] Dr. Duncan Sinclair (50:12).

[40] PricewaterhouseCoopers Healthcare (2000) "Health Care Fraud and abuse: DRG creep," *Issues* (http://www.pwcglobal.com/extweb/manissue.nsf/DocID/80FFF2EE2B921FC9852566D7004D5BC).

2.2.4 Denmark[41]

Most hospitals in Denmark are public hospitals owned and financed by county councils. Fewer than 1% of the total number of beds are in private for-profit hospitals. In the Copenhagen area, the municipally owned and financed hospitals are organized as a public company, the Copenhagen Hospital Corporation. The corporation is controlled by a board, with members appointed by the municipalities and the national government, including representatives from the private sector.

Until recently, the predominant method for allocating resources to hospitals was through prospective global budgets fixed by county councils. Large capital investments are decided jointly by county councils and hospitals and provided through project-based funding.

While global budgeting proved effective in controlling hospital expenditures, it provided limited economic incentives to increase efficiency at the point of delivery, and limited incentives to increase activity in relation to demand, thus contributing to increasing waiting lists for some procedures. In response to these inefficiencies, funds were allocated to the counties in 1997 to allow them to experiment with service-based funding. To increase the incentives to treat patients from other counties, in 1999 the national government decided to introduce full DRG payments for the treatment of such patients. The use of deliberately high DRG rates was expected to increase competition between hospitals.

In 2000, the national government formally introduced a system combining global budget and DRG rates with negotiated activity targets for each hospital. Under the new scheme, each hospital receives an up-front budget corresponding to 90% of the DRG rates related to the case-mix in the negotiated activity target, with the remaining 10% allocated according to the actual activity performed. Hospitals that provide more treatments than their negotiated target receive extra funds. The national government plans to encourage experiments in which more than 10% of a hospital's income is activity based.

2.2.5 Norway[42]

Fewer than 1% of all hospital beds and 5% of outpatient services in Norway are private. Norway's counties are responsible for financing all public hospitals, with the exception of one regional hospital owned and operated by the national government.

Between 1980 and 1997, Norwegian hospitals received global budgets from their counties. While it was agreed that this system allowed governments to control costs and the distribution of resources, a Royal Commission, appointed in 1987, found that global budgets encouraged some hospitals to restrict their services in order to keep within their budgets.

As a result of the commission's recommendations, counties, on behalf of hospitals, were remunerated by the national government by a combination of cost per case, based on the DRG system, and global budgets. The reform, introduced in 1997, was intended to increase hospital in-patient activity, raise productivity and shorten waiting lists. The new payment method was introduced gradually: in 1997, 70% of grants to counties were according to a needs-based formula while the remaining 30% were paid based on the previous year's in-patient activity, using national standard DRG rates. In 1998, this was changed to 55% formula-based and 45% activity-based and finally moved to a 50-50 split in 1999. Since 1999, day care surgery has been financed based entirely on the DRG system. Teaching hospitals receive two additional grants: one to cover teaching and research, and the other to finance the treatment of complex and costly patient cases.

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[41] The information provided in this section is based on European Observatory on Health Care Systems, *Health Care Systems in Transition – Denmark*, 2001. http://www.euro.who.int/observatory/TopPage).

[42] The information provided in this section is based on European Observatory on Health Care Systems, *Health Care Systems in Transition – Norway*, 2000. (http://www.euro.who.int/document/e68950.pdf).

2.2.6 Review of international experience by the Comité Bédard

In June 2000, the Quebec Department of Health established a task force to examine the financing of hospitals in the province. This task force, the *Comité sur la réévaluation du mode de budgétisation des centres hospitaliers de soins généraux et specialisés*, was headed by Denis Bédard. The *Comité Bédard* released its report in December 2001. One section of the report reviewed hospital budgeting in the United States, United Kingdom, France, Belgium and Norway. The *Comité Bédard* made a number of interesting observations based on this international review:

- Population-based approaches are widely used and recognized as an equitable mode for funding hospitals.
- There is a move away from global budgeting and a trend towards deploying information systems based on the DRG model.
- Countries are looking for mechanisms that can link information on hospital use and hospital delivery of services.
- There is a trend toward the development of more sophisticated methods for assessing hospitals' financial performance.
- More emphasis is placed on quality of care in the delivery of hospital services.

Overall, the *Comité Bédard* recommended a budgeting method for Quebec hospitals based on DRGs and performance. It was recognized that adjustments would have to be made for teaching hospitals. The *Comité Bédard* also recommended that the Quebec Department of Health build on the work of the Canadian Institute for Health Information (CIHI) rather than attempting to develop its own database on case-mix groups (CIHI's work is discussed in more detail below).

2.3 The Rationale for Service-Based Funding in Canada

It has been recognized both in Canada and internationally that detailed information on the use of hospital (and other) resources is essential to the efficient delivery of desired outcomes in health care. With current approaches to funding hospitals in Canada, decisions are not usually based on detailed costing information, since funding is either decided politically or based on historical trends and, in any case, the necessary information is just not available.

The Committee believes that current hospital funding mechanisms, where these are based on funding inputs and not on final outcomes, must be revised to focus on performance in delivering hospital services.

As explained in Section 2.1 above, provinces have tried recently to improve their decision-making ability by introducing funding models that depend on more and better information, such as population-based funding. However, this method for determining budgets can provide only rough estimates of what a hospital's needs might be. Moreover, depending on the efficiency of the facility, there is no guarantee that the hospital will successfully and effectively turn these resources into the desired services with the desired outcomes. Therefore, the Committee believes that current hospital funding mechanisms, where these are based on funding inputs and not on final outcomes, must be revised to focus on performance in delivering hospital services.

The majority of the witnesses that appeared before the Committee supported the idea of moving to service-based funding for hospitals. For example, Michael Decter, former Deputy Minister of Health in Manitoba and Ontario and currently Chairman, Board of Directors, Canadian Institute for Health Information (CIHI), stated:

> *The right way of funding hospitals, in my view, is to fund them for what they do, for what they actually accomplish in outcome terms.*[43]

The following advantages of service-based funding were brought to the attention of the Committee:

- Better Information – Witnesses told the Committee that service-based funding increases the need for better information, something the Committee considers essential to measure the performance of the health care system in terms of quality and outcomes.[44] In fact, the lack of critical information currently hobbles health care providers and government decision-makers alike. In its brief, the Canadian Healthcare Association indicated that: "Our members fully support the need for costing services and improving performance measurement and benchmarking."[45]
- Transparency and Accountability – Witnesses stressed that, because the service-based approach relates funding to the actual services provided by a hospital, accountability for the use of public funds and transparency of costs would be substantially improved. For example, the submission of the Ontario Hospital Association to the Committee stated that "the public would see the direct connection between the level of funding and the number and types of procedures that are performed, thereby opening up health care funding to public scrutiny."[46]

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[43] Michael Decter (52:12).

[44] Mark Rochon, Ontario Hospital Association (56:43).

[45] Canadian Healthcare Association, Brief to the Committee, June 2002, p. 6.

[46] Ontario Hospital Association, Brief to the Committee, May 22, 2002, p. 36.

- Equity in the Distribution of Funding – With its "price times volume" approach, many witnesses considered service-based funding to be a more equitable means of funding hospitals than through current methods.[47] In addition, by attaching a price to specific hospital services, service-based funding enables the funder to influence change by changing the value attached to specific services.

- Investment in Capital – Dr. Les Vertesi informed the Committee that the health care system in Canada is "under-capitalized." He blamed this on the use of global budgets, which do not attract capital. He argued that service-based funding, on the other hand, attracts outside capital to build facilities.

- Independence – Many witnesses believed that a move to service-based funding would result in hospitals becoming more independent from government. This would help to de-politicize decision-making with respect to hospital services. The Canadian Healthcare Association disagreed with this point, arguing that service-based funding would most likely lead to greater rather than less micromanagement by governments.[48] The Committee does not share this view. Along with the majority of witnesses, we believe that service-based funding will provide hospitals with the needed flexibility to allocate financial and human resources according to principles of best practice, efficiency and locally-determined needs.

- Reduction in size of Provincial Health Departments – Indeed, the Committee believes that service-based funding will enormously reduce the amount of top down, control and command micromanagement of hospitals which now characterizes all provincial departments of health. The reduction in the role of these departments should lead to a corresponding reduction in the number of their employees.

- Patient-Oriented Service Delivery – Dr. Vertesi stated that by paying hospitals for the services they actually provide, patients become a source of income rather than a burden to the facility. Service-based funding creates incentives for providers to increase efficiency, service volumes, and patient satisfaction, precisely what is needed currently.[49]

- Efficiency and Performance – Current hospital funding mechanisms do not provide the right incentives and often produce perverse results with respect to financial management. In fact, a 1998 study by the Ontario Joint Policy and Planning Committee showed that with global budgets there is no correlation between hospital deficits/surpluses and cost-efficiency in the Ontario hospital sector. More precisely, the study concluded that there are a number of inefficient Ontario hospitals that run budget surpluses and an even greater number that are considered cost-efficient but have deficits.[50]

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[47] This opinion was also expressed by Ladak (1998), *op. cit.*, p. 3.

[48] Canadian Healthcare Association, Brief to the Committee, p. 7.

[49] Les Vertesi (2001), *op. cit.*, p. 118.

[50] Ontario Joint Policy and Planning Committee Financial Issues Advisory Group (1998), "Understanding the Financial Pressures of Ontario Hospitals: Short and Long Term Solutions", Document No. RD 7-10.

Service-based funding changes the financing perspective from paying hospitals a specific amount to meet their anticipated needs to paying them according to what they actually do. As elsewhere in the economy, this fosters both efficiency and performance.

- Multiple Ownership Structures – The combination of a single funder/insurer, service-based funding and the separation of funder and provider means that the funder is neutral on the issue of who owns a hospital. The funder/insurer would purchase the service from that institution offering the best price, provided that it met the necessary quality standards. Such an institution could be either publicly owned or owned by a private not-for-profit or for-profit organization. As indicated in Volume Five, the Committee believes that the patient and the funder/insurer will be served equally no matter what the corporate ownership of a health care institution maybe, as long as the two following conditions are met: 1) all institutions in a province are paid the same amount for performing any given medical procedure or service; 2) all institutions, no matter their ownership, are subjected to the same rigorous, independent quality control and evaluation system. The Committee emphasizes that it is not pushing for the creation of private, for-profit, facilities. But we do not believe that they should be prohibited, just as they are not now prohibited under the *Canada Health Act.*[51] Indeed, we fully expect that the overwhelming majority of institutional providers would continue to be, as they are now, privately owned, not-for-profit institutions.[52]

The Committee emphasizes that it is not pushing for the creation of private, for-profit, facilities. But we do not believe that they should be prohibited, just as they are not now prohibited under the Canada Health Act.

- Flexibility in Changing Priorities – Service-based funding allows government to change priorities with respect to particular procedures and services by altering the amount it will pay for them.
- Competition to Provide the Best Services – Service-based funding will lead to particular services being provided at hospitals which are most efficient and perform the greatest number (highest volumes) of these services. Competition in the provision of services will improve quality and force those hospitals that wish to continue providing particular services to do so even more efficiently.
- Centres of Excellence – The Committee heard many times that a service-based funding method would lead to the development of centres of specialization – or "centres of excellence", as they were referred to by a

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(www.ippc.org)

[51] This point is clearly enunciated in a document prepared for the Commission on the Future of Health Care in Canada by Colleen Flood and Sujit Choudhry, *Strengthening the Foundations: Modernizing the Canada Health Act*, Discussion Paper No. 13, August 2002.

[52] Volume Five, pp. 38-39.

> number of witnesses – for the provision of certain treatments or surgeries. Such change in the delivery of hospital services should be encouraged because of the efficiencies it brings. This would also contribute to improving the quality of services. Indeed, recent articles in the *New England Journal of Medicine* have shown that the best indicator of quality, whether it is surgery or a diagnostic procedure, is volume. The advantages of specialization for selected hospital services were acknowledged by provincial premiers and territorial leaders who agreed, at their January 2002 meeting, to share human resources and equipment by developing "Sites of Excellence" for a number of complex surgical procedures.[53] There are, obviously, desirable limits to the Centre of Excellence concept that are reached when accessibility to services is compromised by virtue of the fact that the hospital offering a particular service is far away. A balance thus needs to be struck between the quality and cost-effectiveness/efficiency principles and that of ready accessibility.[54]

While most witnesses stated that they supported a move to service-based funding for hospitals, the Committee was cautioned that there are a number of substantial challenges in the implementation of such a funding model. These challenges are summarized below.

2.3.1 Appropriateness of service mix

Service-based funding is attractive to hospital managers because they are responsible for choosing which services their institution will provide and at what levels. With this discretion available to management, hospitals will adjust their service mix in order to earn the highest possible returns consistent with meeting the needs of the population they serve. Hospitals will be encouraged to specialize in those services they can do best, and those for which the rates of remuneration are most attractive; they will reduce to the point of not providing those low-volume services that are not, for them, appropriately funded. In highly populated urban areas, this would lead to facilities specializing in the provision of certain services. However, the Committee was told that in smaller, rural communities, particularly those located some distance from a major urban centre, preserving accessibility to particular services may well claim priority. In this case, hospitals may choose to continue to provide needed services despite relatively low rates of remuneration. It is, therefore, essential that rates be reviewed and revised on a regular basis. The concerns with respect to small and rural community hospitals are discussed in Section 2.5.

2.3.2 Over-servicing and up-coding

With a hospital's finances dependent on the volume and mix of services it provides, incentives are created to encourage efficiency and to increase productivity. There is concern, however, that remunerating hospitals for each service performed could lead to over-servicing and, possibly, improper billing ("DRG creep"). The issue of over-servicing arises with physicians who are paid on a fee-for-service basis. The Committee believes that this method of payment has led some physicians to concentrate on the number of patients seen rather than quality of their care. The Committee was told, however, that while the possibility of over-servicing always exists with hospitals, it is less likely to occur given that many "players", such as referring and consulting physicians and, of course, patients themselves, are involved in every decision to provide a given person with a specified service in hospital.

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[53] Specialized hospital services include for example paediatric cardiac surgery and gamma knife neurosurgery.

[54] For example, with paediatric coronary surgery, given the relatively small number of children affected and the generally reparative nature of the problems (as opposed to life-threatening), the case is compelling to concentrate those procedures in very few centres (as is now being done in Ontario). But for adult coronary artery by-pass, for example, it would make no sense to have only one Centre in Ontario doing them.

In the opinion of Dr. Duncan Sinclair, former Commissioner of the Ontario Health Services Restructuring Commission:

> *[t]he danger is very much less in hospitals, given that the hospital itself is not the gatekeeper. However, one would have to be careful to avoid collusion between those who are the gatekeepers of hospital function and the hospitals themselves.*[55]

Some witnesses stressed that over-servicing is especially dangerous in a system such as that in Canada where hospital-based specialists are also paid under a fee-for-service scheme. This problem can be greatly alleviated, however, by having hospital-based specialists paid under a different remuneration scheme, as in Sweden and the United Kingdom.

Under a service-based funding system, cases are given weights in relation to their severity and the corresponding use of resources: the higher the case weight, the greater the remuneration. Therefore, hospitals have an incentive to up-code, that is, to report the highest weight for each case, whether this classification is justified or not.

Michael Decter raised the concern of improper billing or up-coding with respect to service-based funding:

> *I think service-based funding is the right way with a couple of caveats. You must have a system that is well enough documented and data strong enough you do not get gamed. As you will remember, a major hospital chain in the U.S. – HCA Columbia – was litigated by the government of the United States for cheating them to the tune of hundreds of millions, if not billions of dollars, by having their thumb on the scale on the coding.*[56]

Audits, fines and penalties will have to be put in place to prevent abuse of the payment system. A detailed and accurate set of costing rates will also reduce the incentives to up-code. Having an independent system of evaluation, as recommended in Chapters One and Ten, would alleviate this problem to a great extent.

2.3.3 Rates, information and data

Before service-based funding can be implemented, reliable case costing information and methodologies must be developed. Sharon Scholzberg-Gray, President and CEO of the Canadian Healthcare Association, informed the Committee that shifting to an entirely service-based funding system requires costing data that do not yet exist. In its brief, the Association also indicated that:

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[55] Duncan Sinclair (50:12).

[56] Michael Decter (52:13).

> *The costing data that has been developed in Ontario has taken 10 years to develop. While it has been an important and necessary initiative, there are still significant operational issues to deal with including: the fact that this process only covers 50-60% of hospital services (it does a good job of inpatient services and surgeries, but not outpatient services); there is a need to add "complexity factors" (such as recognizing the unique situation of remote hospitals and teaching hospitals); and the tendency to allocate administrative costs to services that are not covered by the process, thus appearing to be very efficient. Given the ongoing challenges of establishing an Ontario system, one can imagine the magnitude and complexity of issues that need to be resolved when developing a pan-Canadian costing system.*[57]

Currently, the Canadian Institute for Health Information (CIHI) is responsible for the collection, establishment and revision of service case rates. The work on collecting costing data in Canada began in 1983, when the Hospital Medical Records Institute undertook to develop a Canadian database on case-mix groups, which is now maintained by CIHI. At the time of implementation, the lack of comprehensive Canadian case-mix costing data resulted in the importation of American cost data (New York State and Maryland) that were adjusted for Canadian lengths of stay. Now, CIHI uses data from selected hospitals in Alberta and Ontario to estimate the case-mix weights.

Kevin Empey, Chief Financial Officer of University Health Network in Toronto, stressed that more hospitals must submit costing data if accurate remuneration rates are to be established. He indicated, for example, that in 2000 only 2 of the 13 teaching hospitals in Ontario and 3 of the province's 69 community hospitals, along with a small number of Alberta hospitals, provided costing data for the establishment of Canadian case rates.[58] In order to develop sufficiently current and detailed rates, it is essential that the majority of hospitals be required to produce and submit costing data. Kevin Empey also stressed that:

> *We need a system which either creates an incentive or a penalty to motivate institutions to provide data and to participate in the inputting of it. This would end up with a better structure and better data.*[59]

2.3.4 Innovation

In its brief, the Canadian Healthcare Association argued that service-based funding, with its focus on providing services at the lowest cost, would discourage innovation, both with respect to new procedures and new technology.[60] This is especially a concern for Academic Health Sciences Centres and teaching hospitals. Teaching facilities must be able to try new and highly specialized, but very costly, procedures without being put at risk by a rate-based system. It is therefore important that case-mix funding approaches not create perverse incentives by discouraging innovation of this (or any) kind. The concerns raised with respect to teaching hospitals are discussed in Section 2.4.

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[57] Canadian Healthcare Association, Brief to the Committee, p. 7.

[58] Kevin Empey (56:45).

[59] *Ibid.*

[60] Canadian Healthcare Association, Brief to the Committee, p. 6.

2.3.5 Comprehensive health care

Members of the Canadian Healthcare Association pointed out that service-base funding focuses on "procedure-driven" health care instead of the provision of comprehensive and integrated care. In other words, service-based funding would simply encourage health care providers to respond to sickness and to concentrate less on a broad continuum of services, including health promotion and disease prevention. They felt that funding under global budgets helped to provide more extensive care than service-based funding would be able to. Indeed, Mark Rochon of the Ontario Hospital Association, who supported the idea of a move towards service-based funding, also made the comment:

> *I think we need also to recognize that there are some aspects of service that perhaps ought to be funded with other than a service based approach. I am thinking, for example, of services that relate to health promotion and prevention. Perhaps the argument could be made that stand-by services such as emergency rooms could also be funded on a global basis.*[61]

2.3.6 Escalation of costs

In the opinion of the Canadian Healthcare Association, it was precisely this type of procedure-driven care – one that would be fostered by service-based funding – that has resulted in an escalation of costs:

> *The cost escalations currently being experienced within our health system are almost entirely related to "cost of procedures" related to physician services and drug costs. Service based funding would encourage a continuation of these current practices.*[62]

The Committee does not support this opinion. As stated in Volume Five, we believe that service-based funding fundamentally changes the incentives, with the result that cost escalation will be reduced in the long run.[63]

2.3.7 Lack of simplicity

Many witnesses told the Committee that if service-based funding were to be implemented, a number of adjustments would have to be made to the rates in order to accommodate institutions such as teaching hospitals and smaller, rural hospitals. Sharon

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[61] Mark Rochon, Ontario Hospital Association (56:43)

[62] Canadian Healthcare Association, Brief to the Committee, p. 6.

[63] Volume Five, pp. 36-39.

Sholzberg-Gray, President and CEO of the Canadian Healthcare Association, observed that while the vast majority of the witnesses supported service-based funding, each witness suggested modifications that, in aggregate, could lead to an extremely complex funding system:

> *What we noted in reviewing some of the testimony of people who came before this Committee to speak about service based funding is that (...) they all wanted special complications formula – that is, if you are a teaching hospital, one formula; if you are in a remote area, a different approach; if you do certain things, another approach.*[64]

The Committee has already acknowledged in Volume Five that some adjustments would be necessary to service-based funding to accommodate the variety of hospitals.[65] The adjustments that would have to be considered for teaching centres and for small rural hospitals are discussed in Sections 2.4 and 2.5 of the present volume.

2.3.8 Committee commentary

The Committee believes that service-based funding has numerous advantages over the methods currently used to finance hospitals in Canada.

The Committee concurs with witnesses that, as much as possible, hospitals should be funded for the specific services they provide, that is, according to service-based funding. Service-based funding is the most appropriate method for financing the operational costs of hospitals, though we recognize that additional investment may be needed for capital purposes in many Canadian hospitals (see Section 2.6 below). The Committee believes that service-based funding has numerous advantages over the methods currently used to finance hospitals in Canada. In our view, Canadians will greatly benefit from service-based funding in terms of quality and timeliness of hospital care, as well as in terms of transparency, accountability and performance reporting.

The Committee recognizes that hospital funding is a provincial matter; nonetheless, the federal government could be of considerable assistance in promoting of service-based funding. In our view, the federal government, as part of its role in supporting the health care infrastructure and the health info-structure (see Volume Four)[66], should provide some of the funding necessary to enable the provinces to implement service-based funding. This federal funding should be part of the federal investment in health information systems that this Committee recommends in Chapter Ten. Furthermore, the Committee believes that CIHI can play a major role in the estimation of case-mix groups and their relative weights, both of which are needed to implement service-based funding.

If Canadians are to derive the most benefits from publicly funded or insured hospital services, service-based funding must be implemented. Moreover, hospitals also will gain a lot from service-based funding. This mode of remuneration will allow them to identify inefficient practices and hence help improve their productivity. As a result, hospitals will be able to compete on the basis of quality of care.

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[64] Sharon Sholzberg-Gray (60:27).

[65] Volume Five, pp. 36-39.

[66] Volume Four, pp. 95-105.

The Committee acknowledges that the implementation of service-based funding will take time. Following the experience in European countries, the new payment method should be introduced gradually; at the early stages, hospitals should be remunerated by a combination of service-based funding and their traditional funding methods. The portion of funding allocated through service-based funding should grow each year and that allocated by the traditional methods should shrink correspondingly, until at the end of the implementation period hospitals are remunerated entirely by service-based funding.

For instance, similar to the Norwegian experience, the funding split might begin with hospitals being remunerated 70% by traditional methods and 30% through service-based funding. The funding mix might then progress to a 50-50 split, to 70% service-based funding, and then finally to 100% service-based funding.

Therefore, the Committee recommends that:

Hospitals should be funded under a service-based remuneration scheme. This method of funding is particularly well suited for community hospitals located in large urban centres. In order to achieve this, a number of steps must be undertaken:

- **A sufficient number of hospitals should be required to submit information on case rates and costing data to the Canadian Institute for Health Information;**
- **The Canadian Institute for Health Information, in collaboration with the provinces and territories, should establish a detailed set of case rates to reduce incentives to up-code.**
- **The federal government should devote ongoing funding to the Canadian Institute for Health Information for the purpose of collecting and estimating the data needed to establish service-based funding.**
- **The shift to service-based funding should occur as quickly as possible. The Committee considers a five-year period to be a reasonable timeframe for the full implementation of the new hospital funding.**

2.4 Academic Health Sciences Centres and the Complexity of Teaching Hospitals

AHSCs consist of a teaching hospital, a university faculty of medicine, and other health-related research and health care institutes. Because these centres are responsible for not only patient care but also teaching and research, they are much more complex than community hospitals.

Teaching hospitals in Canada form part of what is known as Academic Health Sciences Centres (AHSCs). AHSCs consist of a teaching hospital, a university faculty of medicine, and other health-related research and health care institutes (see Appendix 2.1 for a list of the 16 AHSCs in Canada and their affiliated hospitals). Because these centres are responsible for not only patient care but also teaching and research, they are much more complex than community hospitals. They also offer the newest and most highly sophisticated services and treat the most difficult, complex cases.

Hospitals with teaching/research activity have higher costs per weighted case than community hospitals. This is due to the required teaching infrastructure, specialized programs, higher utilization of diagnostic testing, and the use of resources needed for more innovative and aggressive treatment procedures:

> *Studies have shown that procedure costs at academic health science centres are higher than in community hospitals. This is not only due to the costs of the complexity of care provided or the introduction and evaluation of leading-edge practice. To fulfill its teaching and research mandate, some clinical procedures cost more than average and result in lengths of stay that may be longer than average. Additionally, a major research and education centre incurs facility and operating costs as a result of providing space and supporting the medical staff in these endeavours.*[67]

Because of the educational and research aspects of AHSCs, funding comes traditionally from at least two separate provincial government departments and, within those departments, from a variety of sources. While it is almost impossible to distinguish precisely the academic mission from the health care delivery mission, government funding can be placed into three broad categories.[68]

First, the department of education provides operating grants to universities that in turn provide budgets for health faculties, including salaries for their academic staff. Second, the department of health provides hospitals with budgets for clinical education to pay the salaries of post-graduate trainees and partial support of the incomes of clinical faculty. Third, hospitals receive operating grants from provincial health ministries to help pay for the added cost of research and training activity.

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[67] S. Kevin Empey, Brief to the Committee, 22 May 2002, p. 12.

[68] Lozon and Fox (2002), *op. cit.*, p. 16.

As a result of this complexity, service-based funding poses a number of problems particular to AHSCs. Patients of AHSC often require very sophisticated treatment, the cost of which may not be accurately captured in case-mix measurement systems. For instance,.Kevin Empey, Chief Financial Officer, University Health Network (Toronto), stated:

> *(...) both pacemaker and defibrillator implants are included in the same [case-mix group] and thus would be assigned the same case weights and funded identically. This weighting, and any rate-based funding would not reflect the dramatic differences in the costs of the devices implanted. The cost of a typical defibrillator implant procedure is approximately 2.5 times that of a pacemaker implant.*[69]

Similarly, it is estimated that the cost of one multi-organ transplant costs $213,000 per patient. However, due to the complexity and the uniqueness of the treatment, rates have not been determined in Canada for the transplants. As a result, teaching hospitals in Toronto receive funding at the same rate as for single-organ transplants, which is a fraction of the true cost of the multi-organ treatment.[70] For these reasons, Dr. Hugh Scott of the McGill University Health Centre stated:

> *if you want to put it in a formula, there has to be multiples. Any time we try to put cardiac surgery and psychotherapy in a magic formula, there will be problems. When you then add in a teaching environment and so on, you will have even more problems. I look forward to simplicity and elegance, I think sometimes multiple factors have to be taken into account.*[71]

Dr. Jeffrey Lozon from St. Michael's Hospital (Toronto) discussed the complexity of financing teaching hospitals given the variety of activities they perform:

> *The most appropriate funding vehicle is the one that most closely aligns the accountability of the academic health sciences centre and its outputs in a fair funding system. Our centres are accountable for their outputs. However, it must be understood that our outputs are going to be different than what they would be in a community hospital or in a rural environment. They will be more complex. We have different levels of output: we have output around the knowledge that we create; and we have output around the numbers of students that were educated.*
>
> *We would probably be uncomfortable with a one-size-fits-all funding formula that might suggest my hospital be as low cost as a hospital in Yorkton, Saskatchewan. The hospitals do different things and so the cost varies. We need to measure the things we do*

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[69] S. Kevin Empey, Brief to the Committee, 22 May 2002, p. 6.

[70] S. Kevin Empey, *op. cit.*, p.10.

[71] Dr. Hugh Scott (63:17).

> *and we need to be held as accountable as the hospital in Yorkton. However, it is a more complicated endeavour than strictly counting up the dollars.*[72]

The AHSC experts who appeared before the Committee supported the service-based funding methodology as long as case-mix groups and weights are established for AHSCs, distinct from those developed for community hospitals. Such a funding methodology for AHSCs should take into account a variety of factors, including the complexity of procedures and treatments, the introduction of new technologies and the use of costly drugs. Experts also stressed that consideration should be given to funding the cost of teaching and research infrastructure out of a different envelope with its own set of incentives for efficient delivery.

In their recent paper "Academic Health Sciences Centres Laid Bare", Jeffrey Lozon and Robert Fox stated that AHSCs should be considered a national resource in the health care system and that the federal government should enhance its role in the funding of AHSCs. The authors argued that "no longer can the AHSC struggle to arrange funding from a variety of providers and without the support of the federal government."[73]

The Committee agrees with the witnesses that Academic Health Sciences Centres are distinct from community hospitals in that they perform a wide range of complex activities ranging from delivery, to teaching and research. Accordingly, the Committee recommends that:

> **Service-based funding should be augmented by an additional funding method that would take into account the unique services provided by Academic Health Sciences Centres, including teaching and research.**

The Committee believes that AHSCs constitute a national resource in the Canadian health care system. The federal government is particularly well positioned to sustain AHSCs across the country.

Moreover, the Committee strongly believes that, since they play an essential role in teaching, performing research and delivering sophisticated care, AHSCs constitute a national resource in the Canadian health care system. They are a crucial part of the health care infrastructure in Canada. Thus, the federal government is particularly well positioned to sustain AHSCs across the country, through its well-recognized roles in financing post-secondary education, funding health research, supporting health care delivery, financing health care technology and planning human resources in health care. These issues are discussed in subsequent chapters in this report.

2.5 Small and Rural Community Hospitals

Because larger and medium-sized community hospitals do not face the same set of challenges as small or rural community hospitals, problems might arise if the same funding formula were to be applied to both types of hospitals. For example, Raisa Deber, Professor at the University of Toronto, stated that:

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[72] Dr. Jeffrey Lozon (63:16-17).

[73] Lozon, Jeffrey and Robert Fox (2002), "Academic Health Sciences Centres Laid Bare", lead paper in *Healthcare Papers*, Vol. 2 No. 3, p. 30.

> *(...) on issues related to service-based funding, particularly for hospitals in smaller provinces or smaller communities, (...) such funding will not be enough to cover the infrastructure costs of running the organization.*[74]

In addition, the Canadian Healthcare Association indicated in its brief that:

> *Service-based funding would be difficult to implement in rural and remote areas, particularly if there is only one provider and/or organization available to provide services.*[75]

The review of the testimony provided to the Committee suggests that, for the most part, small and rural community hospitals are faced with problems of:

1. Limited economies of scale – Small rural hospitals are often faced with fixed overhead costs and low or unpredictable patient volumes. This leads to higher costs per patient.

2. Isolation – A hospital in rural Canada is considered to be isolated if the next closest hospital is more than 150 km away. That hospital then becomes the primary provider of health care for an entire geographic area. A hospital that is responsible for a large region must be able to provide a greater range of services despite low and sporadic patient volumes.

3. Remoteness – Remoteness refers to the distance between a hospital and the closest tertiary hospital care centre. Hospitals can be remote but not isolated (a number of hospitals may serve a particular region but be at a considerable distance from a tertiary hospital care centre). However, much like isolated hospitals, remote hospitals often have higher fixed overhead costs and must provide a wider range of health care services compared to community hospitals located near tertiary centres. All these factors result in higher costs per patient.

4. Special needs population – Many remote hospitals must care for special needs populations such as residents of First Nations reserves. The health status of these residents is often below the provincial average, which leads to higher admission rates.[76]

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[74] Raisa Deber (59:12).

[75] Canadian Healthcare Association, Brief to the Committee, p. 7.

[76] Ladak (1998), *op. cit.*, p. 31.

Therefore, the funding formula used for larger community hospitals is often not suitable for small and rural hospitals. As a result, the funding formula must take into consideration the particular challenges faced by smaller, rural and remote hospitals.

A number of the witnesses were concerned about the effect of a service-based funding method on the mix of services offered by rural and smaller community hospitals. For example, Mark Rochon of the Ontario Hospital Association stated:

> *We also need to consider that service-based funding should not create incentives for providers to stop offering necessary services in communities. The needs of specific communities must be considered as well as the adequacy of service provided in those communities.*[77]

Kevin Empey, of University Health Network, added that:

> *Some providers, when it becomes a full rate based or service based system, will choose to specialize a little more or get out of something. Certainly in small communities you cannot afford the major providers, that is, the hospitals, to get out of something just because of the rates.*[78]

The Committee agrees with the witnesses that, in order to preserve access to commonly required services, service-based funding should be adjusted to reflect the particular circumstances of small and rural community hospitals. Therefore, the Committee recommends that:

In developing a service-based remuneration scheme for financing of community hospitals, consideration be given to the following factors:

- **Isolation: hospitals located in rural and remote areas are expected to incur higher costs than those in large urban centres. An adjustment should reflect this fact.**
- **Size: small hospitals are expected to incur higher costs per weighted case than larger hospitals. An adjustment should recognize this fact.**

2.6 Financing the Capital Needs of Canadian Hospitals

As indicated in Section 2.1.7, provinces and territories use a method for funding hospital capital expenditures that is different from the method used in relation to funding operating costs. All provinces and territories use a project based method as their capital funding approach. The project based method is well suited to large-scale, one-time projects.

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[77] Mark Rochon (56:43).

[78] S. Kevin Empey (56:45).

The Committee was told that the capital needs of Canadian hospitals are significant. We heard that the current level of capital investment by provincial and territorial governments, along with hospitals' well established fundraising infrastructure and charitable giving, is not sufficient to ensure the sustainability of the hospital sector in Canada. Information provided to the Committee revealed that:

- Between 1982 and 1998, real public per capita spending on new hospital construction decreased from $50 to $2, or a reduction of 5.3% annually.[79]
- Since 1998, real public per capita expenditures on new hospital machinery and equipment has fallen by 1.8% annually.[80]

As a result, there is a substantial gap between the need for new and renovated physical plant and equipment and a hospital's ability to finance capital investment. For this reason, several witnesses proposed that the federal government provide some funding. The Association of Canadian Academic Healthcare Organizations told the Committee that there is precedent in this regard:

> *It should also be noted that there is a precedent when it comes to the role of the federal government in this area. In 1948, the federal government introduced the Hospital Construction Grants Program – which was funded on a cost-sharing basis with the provinces.*[81]

The Canadian Medical Association stated that, in addition to government investment in hospital capital, it may be necessary for hospitals to develop innovative approaches to financing capital infrastructure. According to the Association, there is a need to explore the concept of public-private partnerships to address capital infrastructure needs as an alternative to relying solely on government funding.[82]

While the Committee has supported the consolidation of the hospital sector that has taken place in recent years in all provinces, we are very concerned that the number of beds in some hospitals may not be sufficient to respond to the significant increase in demand for hospital services that exists in a few areas in Canada where there is high and fast population growth. Indeed, we learned that there are a few regions of the country in which population growth has been so great that more hospital beds are needed now and many more will be needed in the coming years. This is particularly true of some metropolitan areas of Alberta (Calgary), British Columbia (Abbotsford, Vancouver), Nova Scotia (Halifax), Ontario (Oshawa, Toronto), Quebec (Montreal), and Saskatchewan (Saskatoon).[83]

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[79] Association of Canadian Academic Healthcare Organizations, Brief to the Committee, 13 June 2002, p. 17.

[80] *Ibid.*

[81] *Ibid.*

[82] Canadian Medical Association, *For Commissioner Romanow: A Prescription for Sustainability*, 6 June 2002, p. 26.

[83] Based on the 2001 Census data of Statistics Canada (http://geodepot2.statcan.ca/Diss/Highlights/).

Accordingly, the Committee believes that the federal government should get involved once again, as it did in 1948, in financially supporting hospitals with the greatest capital needs. Such federal participation would not involve ongoing financing but should rather be considered a "catch-up" measure. Even though it would be a one time measure, federal funding for any given project could be spread over a period of several years.

Specifically, the decision to provide federal support for hospital capital should be made on the basis of a formula that would indicate that, when population growth in a particular region exceeds the provincial average by 50%, the federal government would make one-time only funding available on a cost-shared basis with the province for capital investment in hospital expansion. Such federal investment could work as follows: the hospital should be able to take the federal commitment to pay a fixed amount per year over a 10-year period to a financial institution and borrow against that commitment so that construction could begin right away.

The Committee also believes that provincial/territorial governments should give consideration to public-private partnerships as a means to obtain additional investment in hospital capital. Therefore, the Committee recommends that:

> **The federal government provide capital financial support for the expansion of hospitals located in areas of exceptionally high population growth; that is, areas in which the population growth exceeds the average rate of growth in the province by 50% or more. Such federal financial support should account for 50% of the total capital investment needed. In total, the federal government should devote $1.5 billion to this initiative over a 10-year period, or $150 million annually.**

> **The federal government should encourage the provinces and territories to explore public-private partnerships as a means of obtaining additional investment in hospital capacity.**

Capital investment is also of concern for AHSCs. The Association of Canadian Academic Healthcare Organizations informed the Committee that building replacement is underfunded and depreciation is not fully recognized by the federal and provincial governments for funding purposes. Furthermore, most capital investment decisions appear to be based on short-term responses to needs rather than a long-term planning horizon. In some cases, additions or renovations are made to poor structures, when full reconstruction might have been a better policy decision.

While there are variations in the capital requirements of teaching hospitals, it is clear that significant investment is needed. For example:

- The Montreal University Health Centre has undertaken an evaluation of existing facilities (in which some buildings are 40 to 100 years old) and determined that it will cost $475 million to upgrade its facilities.
- The University Health Network of Toronto estimates that its capital requirements for the next 10 years will be over $500 million (i.e., in excess of $50 million per year).
- The St. John's Healthcare Corporation (Newfoundland) recently completed the development of a Children's and Rehabilitation Centre at a cost of $70 million.

Based on the information made available to the Committee, the Committee concluded that the federal government should contribute some $4 billion for the infrastructure renewal of the 16 AHSC sites. We believe that such federal funding should be provided in response to requests initiated by AHCSs themselves, subject to review by a group of independent experts. This, in our view, would ensure transparency.

More precisely, AHSCs should be required to accompany a request with a sound rationale for additional resources. Each application should be evaluated on its own merits by an independent expert group that would report to the Minister of Health. Moreover, in order to ensure accountability, successful applicants should report on their disposition of the funds received.

Therefore the Committee recommends that:

The federal government contribute $4 billion over the next 10 years (or $400 million annually) to Academic Health Sciences Centres for the purpose of capital investment.

Academic Health Sciences Centres be required to report on their use of this federal funding.

2.7 Public Versus Private Health Care Institutions

Service-based funding means that the insurer (the government) would be neutral with respect to the ownership of a hospital.

In Section 2.3 above, the Committee underlined many advantages to service-based funding for hospitals, one of which relates to the ownership structure of health care institutions. We indicated that service-based funding means that the insurer (the government) would be *neutral* with respect to the ownership of a hospital. The funder/insurer would purchase the service from an institution, provided that it met the necessary quality standards. Since comparable institutions would be paid the same amount of money for a given procedure, and since all institutions would be subject to the same independent and rigorous quality control and evaluation system, the ownership structure would not be a matter of public policy concern. For this reason, the Committee is neutral to the ownership question.

The Committee wants to emphasize that it is not pushing for the creation of private, for-profit, facilities. But we do not believe that they should be prohibited, just as they are not now prohibited under the Canada Health Act. Indeed, we fully expect that the overwhelming majority of institutional providers would continue to be, as they are now, either public or private not-for-profit institutions.

As indicated in Volume Five, the Committee believes that the patient and the funder/insurer will be served equally no matter what the corporate ownership of a health care institution may be, as long as the two conditions enumerated above with respect to pricing and quality control are met. The Committee wants to emphasize that it is not pushing for the creation of private, for-profit, facilities. But we do not believe that they should be prohibited, just as they are not now prohibited under the *Canada Health Act*. Indeed, we fully expect that the overwhelming majority of institutional providers would continue to be, as they are now, either public or private not-for-profit institutions.

Furthermore, the Committee recognizes that there is no reason why the private for-profit provision of publicly funded health services would result in a so-called "two-tier" health care structure, as long as the *funding* of services remains *publicly* based and referrals to institutions continue to be determined by clinical need. This situation with respect to hospitals is no different from the provision of primary health care, most diagnostic services, and some day surgeries – services that are currently delivered in Canada by private for-profit entrepreneurs and facilities.

The Committee recognizes that there is no reason why the private for – profit provision of publicly funded health services would result in a so-called "two-tier" health care structure, as long as the funding of services remains* publicly *based and referrals to institutions continue to be determined by clinical need.

Currently, within Canada's health care system, only 5% of hospital care is delivered by the private for-profit sector. For example, the Shouldice hospital in Ontario is a private for-profit facility; its status was grandfathered when Medicare was enacted in that province. Facilities like this one are regulated on a rate of return basis, to reduce the risk of overcharging patients. In Alberta, private for-profit facilities are allowed, under provincial legislation (Bill 11), to compete with public and private not-for-profit hospitals for the provision of a set of publicly insured surgical services. Canada also has a number of private for-profit health care facilities ("private clinics") that treat only patients who pay privately for the services they receive.

Despite the presence of these private for-profit health care institutions and facilities in Canada, which appear to provide the same quality of care as not-for-profit and public institutions, an intense debate continues about the potential role and impact of for-profit hospitals and clinics in the health care system. This debate culminated in May 2002 with the publication of a meta-analysis study by P. J. Devereaux *et al.* in the *Canadian Medical Association Journal*. This study found, based on a review of 15 different observational studies, "that private for-profit ownership of hospitals in comparison with private not-for-profit ownership in the United States results in a higher risk of death for patients."[84] The authors concluded that the profit motive of private for-profit hospitals may result in limitation of care that adversely affect patient outcomes:

> *Why is there an increase in mortality in for-profit institutions? Typically, investors expect a 10%–15% return on their investment. Administrative officers of private for-profit institutions receive rewards for achieving or exceeding the anticipated profit margin. In addition to generating profits, private for-profit institutions must pay taxes and may contend with cost pressures associated with large reimbursement packages for senior administrators that private not-for-profit institutions do not face. As a result, when dealing with populations in which reimbursement is similar (such as Medicare patients), private for-profit institutions face a daunting task. They must achieve the same outcomes as private not-for-profit institutions while devoting fewer resources to patient care.*[85]

When he appeared before the Committee, Dr. Arnold Relman, Former Editor-in-Chief of *The New England Journal of Medicine*, expressed similar views:

> *(…) most, not all of the current problems of the U.S. health care system, and they are numerous, result from the growing encroachment of private for-profit ownership and competitive markets on a sector of our national life that properly belongs in the public domain. It is no coincidence that no health care system in the industrialized world is as heavily commercialized as ours, and none is as expensive, inefficient, inequitable, or as unpopular. Indeed, just about the only people happy with our current market-driven health care system in the U.S. are the owners and investors in the for-profit industries now living off the system.*[86]

On the basis of this evidence, many observers have noted that it is plausible, if not likely, that the results of the American experience can be generalized to the Canadian context should Canada decide to "open the door" to private for-profit hospitals.

The Committee learned, however, that the Devereaux *et al.* study has a number of caveats. First, Brian J. Ferguson, Professor at the Department of Economics at the University of Guelph (Ontario), informed the Committee in a recent paper that the authors of the meta-analysis specifically excluded public hospitals from their study, on the basis that Canadian hospitals are technically private not-for-profit institutions behaving more or less like American private not-for-profit hospitals.[87] Professor Ferguson argued, however, that private not-for-profit hospitals in the United States do not operate at all in the same environment as Canadian private not-for-profit hospitals: American private not-for-profit hospitals work in a very competitive context and have considerably more freedom in terms of decision-making than their Canadian counterparts.

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[84] P.J. Devereaux *et al.*, "A Systematic Review and Meta-Analysis of Studies Comparing Mortality Rates of Private For-Profit and Private Not-for-Profit Hospitals", in *Canadian Medical Association Journal*, Vol. 166, No. 11, 28 May 2002, pp. 1399-1406.

[85] *Ibid.*, pp. 1404-1405.

[86] Dr. Arnold Relman (48:8-9).

[87] For more information, please consult the recent paper by Brian S. Ferguson, *A Comment on the Deveraux et al. Meta-Analysis of Mortality in Private American Hospitals*, Draft, Department of Economics, University of Guelph, Ontario, June 2002.

In this regard, Professor Ferguson contended that Canadian private not-for-profit hospitals are much more like American public hospitals than they are like American private not-for-profit hospitals. In his view, including public hospitals in the Devereaux *et al.* meta-analysis could have led to very different results.[88] In fact, a number of studies have shown that public hospitals in the United States have higher risk-adjusted 30-day mortality than for-profit hospitals, which in turn have higher mortality than not-for-profit hospitals.[89]

Second, Professor Ferguson also criticized the methodology used by Devereaux *et al.* on several grounds: criteria for the inclusion of pertinent literature; selection of particular results for inclusion in the analysis; choice of the dependent variable; omission of some variables; etc.[90] Finally, in a different paper, Professor Ferguson indicated that it is almost impossible to derive proper conclusions on the potential role of private for-profit hospitals in Canada from the American literature.[91] The health care system in the United States is made up of several public and private insurers, involves a multiplicity of public and private (not-for-profit and for-profit) providers, and operates under intense competitive pressures – a situation that is unlikely to happen in Canada with our single insurer system.

Moreover, the regulatory framework for the provision of hospital care in the United States is different from that in Canada. This explains why we cannot simply transpose what is happening in the United States to Canada. For example, Dr. Arnold Relman told the Committee:

> *Throughout the American health care system there is inadequate regulation of private, for-profit health care, as well as private not-for-profit health care. In the for-profit system, there is so much money in for-profit nursing, hospital care, ambulatory services, and pharmaceutical services that the regulatory agencies have been co- opted, at times you might say intimidated, by the political and financial influence of the owners.*
>
> *(…) In the United States, there is a huge amount of money involved in providing for-profit health care. That money in part is used to ensure that regulation is weak. It applies to the Food and Drug Administration. It applies to all sorts of regulatory agencies. I served for six years on a state agency studying the quality of care in Massachusetts hospitals. It is very clear to me that financial concerns play a major role.*

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[88] *Ibid.*

[89] These studies are summarized in a paper by Stephen Duckett, "Does it Matter Who Own Health Facilities", in *Journal of Health Services Research Policy*, Vol. 6, No. 1, January 2001, pp. 59-62.

[90] Brian J. Ferguson, *op. cit.*, June 2002.

[91] Brian S. Ferguson, *Profits and the Hospital Sector: What Does the Literature Really Say?*, Health policy working paper prepared for the Atlantic Institute for Market Studies, February 2002.

> *(…) If we did have good, aggressive, unbiased regulation, many of the problems I have talked about in terms of quality would be solved. However, we do not.*[92]

The findings of the Devereaux *et al.* analysis also contrast with those a Canadian study published in 1999 in the *Canadian Medical Association Journal* which compared the quality of care in licensed and unlicensed homes for the aged in the Eastern Townships of Quebec.[93] For example, this study found the quality of care provided to elderly residents by large unlicensed (private for-profit) long-term care facilities to be comparable to that of large licensed (private not for profit) facilities.[94] In addition, the study found that the majority of both licensed and unlicensed long-term care facilities (no matter what their size) were delivering care of relatively good quality.

Overall, the Committee acknowledges that the literature on the comparative costs, quality, effectiveness and general behaviour of private for-profit and private not-for-profit facilities is quite extensive. We also recognize that these studies reach mixed conclusions. Some of them suggest that for-profit facilities perform better, while others conclude that not-for-profit facilities or public hospitals do so. Still, other studies have found no difference in the performance of the two.

Given the evidence in the literature, the Committee believes that leaving the *Canada Health Act* as it currently is – which means permitting private for-profit hospitals or clinics to operate under Medicare (since such institutions are not currently prohibited under the Act) – will *not*, as some critics maintain, weaken or destroy the health care system as we know it now. Other advanced countries, with perfectly well functioning universal, publicly funded and organized health care systems (such as Australia, Denmark, Germany, the Netherlands, Sweden and the United Kingdom), already permit private for-profit hospitals to exist; their presence has not caused any insurmountable problems or difficulties.

The Committee believes that leaving the Canada Health Act as it currently is – which means permitting private for-profit hospitals or clinics to operate under Medicare (since such institutions are not currently prohibited under the Act) – will not, as some critics maintain, weaken or destroy the health care system as we know it now.

The debate surrounding public versus private not-for-profit versus private for-profit health care institutions does not seem to arouse the same kind of passion elsewhere. As a matter of fact, the Committee reviewed the operation of the health care system of seven different countries (see Volume Three) and visited three countries (Denmark, Sweden, United Kingdom), and found that there are no articles or studies in European countries and Australia comparing the quality or outcomes of for-profit and not-for-profit or public hospitals. In this sense, this debate is uniquely North American.

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[92] Dr. Arnold Relman (48:23).

[93] Gina Bravo et al., «Quality of Care in Unlicensed Homes for the Aged in the Eastern Townships of Quebec, *Canadian Medical Association Journal*, Vol. 160, No. 10, 18 May 1999, pp. 1441-1445.

[94] The interpretation of the study findings in terms of ownership status (for profit versus not for profit) were facilitated by information provided by the statistician who participated in the realization of this study, Marie-France Dubois.

The Committee believes that it is unlikely that, as a result of the introduction of service-based funding, Canada would see the emergence of full-scale private for-profit hospitals, such as those that operate in Australia or the United Kingdom: in both countries, private health care insurance runs parallel to the public system, and physicians are permitted to have large-scale private practices, a system that seems unlikely to develop in Canada. It is more likely that private clinics would remain small and specialized. Such clinics would emerge in niches where their founders expect to be able to make a profit by operating at lower cost than the public system does, either by taking advantage of economies of scale or, as seems more likely, by taking advantage of economics of specialization. These clinics would bring additional capital into the health care system, since they would be funded privately. This is another reason it is unlikely that they would develop into full-scale general hospitals: private funding for so ambitious, and also risky, an enterprise would be much harder to come by than would funding for specialized clinics.

The Committee strongly believes that there is a need to improve hospital performance and to develop hospital report cards in Canada, regardless of ownership. This can be appropriately done through the independent evaluation process recommended in Chapters One and Ten of this report. Requiring that a single regulatory process apply to *all* health care institutions would contribute much to ensuring high quality of care no matter where it is provided.

Appendix 2.1
Academic Health Sciences Centres in Canada and their Affiliated Hospitals and Regional Health Authorities

1. Memorial University of Newfoundland and Labrador

Healthcare Corporation of St. John's
The General Hospital
St. Clare's Mercy Hospital
Janeway Children's Health and Rehabilitation Centre
Waterford Hospital
Dr. L.A. Miller Centre
Dr. Walter Templeman Health Centre

2. Dalhousie University

Capital Health
IWK Health Centre
Queen Elizabeth Health Sciences Centre II
Dartmouth General Hospital
East Coast Forensic Hospital
Eastern Shore Memorial Hospital
Hants Community Hospital
The Nova Scotia Hospital
Twin Oaks Memorial Hospital
Musquodoboit Valley Memorial Hospital
Atlantic Health Sciences Corporation*
Saint John Regional Hospital
St. Joseph's Hospital
Sussex Health Centre
Charlotte County Hospital
Grand Manan Facility

3. Université Laval

Centre Hospitalier Universitaire de Québec
Hôpital Laval, Institut Universitaire de Cardiologie et de Pneumologie

4. Université de Sherbrooke

Centre Universitaire de santé de L'Estrie
Sherbrooke Geriatric University Institute

5. Université de Montréal

Centre Hospitalier de l'Université de Montréal
Hôpital Sainte-Justine
Institut Cardiologie de Montréal
Hôpital Maisonneuve-Rosemont
Hôpital du Sacré-Coeur de Montréal

Institut Universitaire de Gériatrie de Montréal

6. McGill University
Montreal University Health Centre
Jewish General Hospital
St. Mary's Hospital
Douglas Hospital

7. University of Ottawa
Sisters of Charity of Ottawa (SCO) Health Services
Ottawa Hospital
Children's Hospital of Eastern Ontario

8. Queen's University
Kingston General Hospital
Hotel Dieu Hospital
Providence Continuing Care Centre

9. University of Toronto
University Health Network
St. Michael's Hospital
The Hospital for Sick Children
Sunnybrook Health Sciences Corporation
Mount Sinai Hospital
Toronto Rehabilitation Institute
Baycrest Centre for Geriatric Care
Centre for Addiction and Mental Health

10. McMaster University
Hamilton Health Sciences Centre
St. Joseph's Hospital

11. University of Western Ontario
London Health Sciences Centre
St. Joseph's Health Centre

12. University of Manitoba
Winnipeg Regional Health Authority
St. Boniface General Hospital
Health Sciences Centre

13. University of Saskatchewan
Saskatoon District Health Board
Royal University Hospital
Saskatoon City Hospital
St. Paul's Hospital
Regina Health District
Regina General Hospital
Pasqua Hospital

14. University of Calgary
Calgary Health Authority
Rockyview Hospital
Foothills Hospital
Alberta Children's Hospital
Peter Lougheed Hospital

15. University of Alberta
Capital Health Authority
Royal Alexandra Hospital
University of Alberta Hospital
Grey Nuns and Misercordia Hospital

16. University of British Columbia
Provincial Health Services Authority
Children's and Women's Health Centre
BC Cancer Agency
Vancouver Coastal Health Authority
Vancouver Hospital and Health Science Centre
Providence Health Care/St. Paul's Hospital

Source: Based on information provided by Glenn Brimacombe, Chief Executive Officer, Association of Canadian Academic Healthcare Organizations.

*AHSC functions as main New Brunswick campus for Dalhousie University and Memorial University of Newfoundland and Labrador.

CHAPTER THREE

DEVOLVING FURTHER RESPONSIBILITY TO REGIONAL HEALTH AUTHORITIES

In Volume Five of its study on health care, the Committee advocated major restructuring of the hospital and doctor system, leading to the devolution of operational responsibility for health care spending from provincial governments (ministries of health) to regional health authorities (RHAs). Under such reform, RHAs would become responsible for purchasing health services from hospitals and other health care institutions on behalf of the populations they serve. If a province so wished, RHAs could also become responsible for purchasing primary health care and prescription drugs.[95] Devolving responsibility for the *full* range of health services from provincial ministries of health to RHAs would lead to a better-integrated, more coordinated and truly patient-oriented system of health care delivery.

This type of reform, which has already been implemented in varying degrees in a number of countries, including Sweden and the United Kingdom, was also proposed in the report of the Premier's Advisory Council on Health in Alberta (the Mazankowski report).[96] The Committee believes that RHAs have done a commendable job of integrating and organizing health services for people in their regions during the last decade in Canada, and that they should be given more responsibility and authority for delivering and/or contracting for the full range of publicly insured health services.

The Committee believes that RHAs have done a commendable job of integrating and organizing health services for people in their regions during the last decade in Canad,a and that they should be given more responsibility and authority for delivering and/or contracting for the full range of publicly insured health services.

The Committee also believes that such reform would foster competition among health care providers (both individual and institutional) and encourage cost-effectiveness and efficiency in service delivery. As stated in Volume Five, the Committee is aware that reforms of this type will have to be adapted to the particular circumstances that prevail in different parts of the country in order to take into account the number and type of health care providers that operate in each region, as well as factors such as the urban/rural mix. We also acknowledge that the goals intended by this reform will have to be achieved through other means in Ontario, the Yukon and Nunavut, since there are no RHAs in these jurisdictions.[97]

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[95] Volume Five, pp. 39-40.

[96] Premier's Advisory Council on Health, (Right Hon. Don Mazankowski, Chair), *A Framework for Reform*, December 2001 (http://www.premiersadvisory.com/).

[97] The Committee was told that one of the reasons explaining why there are no RHAs in Ontario is the fact that the Greater Toronto Area is too big for a RHA. One possibility could be to consider implementing the RHA model elsewhere in that province, while another model allowing for the integration of care could be implemented in the GTA.

This chapter is divided into five sections. Section 3.1 provides a general portrait of RHAs across Canada in terms of their current structure, size, scope of responsibility and funding. Section 3.2 reviews the objectives for which RHAs were established and summarizes RHAs' achievements in light of those objectives. Section 3.3 discusses the barriers which currently prevent RHAs from fulfilling their responsibilities to their fullest potential. Section 3.4 describes how reforms based on some "internal market" approaches have the potential to address these concerns through the devolution of further responsibility to RHAs. Finally, Section 3.5 enunciates the Committee's position on the role of RHAs in Canada.

3.1 RHAs Across Canada: A Portrait[98]

In Canada, regional health authorities are playing an ever-increasing role in health care. In the past 14 years, all provinces (except Ontario) and the Northwest Territories have devolved responsibility for the management of substantial parts of the health care system from provincial/territorial governments (ministries of health) to RHAs. The common definition for RHAs in Canada is as follows:

> *Regional health authorities are autonomous health care organizations with responsibility for health care administration within a defined geographic region within a province or territory. They have appointed or elected boards of governance and are responsible for funding and delivering community and institutional health services within their regions.*[99]

Despite this common definition, RHAs across Canada differ greatly in size, structure, scope of responsibility, and number per province/territory. Table 3.1 provides information on the current number and approximate date of establishment of RHAs in each jurisdiction, as well as data on the population served. Regionalization of health care is a fairly recent phenomenon in many provinces. While some provinces have recently reduced the number of RHAs (for example, British Columbia went from 52 to 6), others have increased the number (by 1 in New Brunswick and from 4 to 9 in Nova Scotia). In addition, the size of the population served by a RHA varies widely both between and within provinces.

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[98] Unless otherwise indicated, the information contained in this section is based on the following documents:

Ontario Hospital Association, *Regional Health Authorities in Canada – Lessons for Ontario*, Discussion Paper, January 2002 (www.oha.com).

Regionalization Research Centre, *What is Regionalization?* (http://www.regionalization.org/).

Ian McKillop, George H. Pink and Lina M. Johnson, *The Financial Management of Acute Care in Canada. – A Review of Funding, Performance Monitoring and Reporting Practices*, Canadian Institute for Health Information, March 2001 (http://www.cihi.ca/dispPage.jsp?cw_page=GR_32_E).

Peggy Leatt, George H. Pink and Michael Guerriere, "Towards a Canadian Model of Integrated Health Care", *HealthCare Papers*, Vol. 1, No. 2, Spring 2000, pp. 13-35.
(http://www.longwoods.com/hp/spring00/Papers2.pdf)

British Columbia Medical Association, *Regionalization of Health Care*, BCMA Policy and Reports, 1997 (http://www.bcma.org/IssuesPolicy/PolicyPapersReports/regionalization/default.asp).

Jonathan Lomas, *Regionalization and Devolution: Transforming Health, Reshaping Politics?* Occasional Paper No. 2, October 1997 (http://www.regionalization.org/OP2.pdf).

Jonathan Lomas, "Devolving Authority for Health Care in Canada's Provinces: 1. An Introduction to the issues", *Canadian Medical Association Journal*, Vol. 156, Issue 3, February 1997, pp. 371-377 (http://www.cmaj.ca/).

[99] Definition provided by the Regionalization Research Centre.

TABLE 3.1
REGIONAL HEALTH AUTHORITIES (RHAs), 2002

	DATE ESTABLISHED	NUMBER OF RHAs	POPULATION SERVED (range or average)
British Columbia	1997	6	320,000 to 1.3 million
Alberta	1994	17	20,000 to 900,000
Saskatchewan	1992	12	30,000 to 50,000
Manitoba	1997-1998	12	7,000 to 650,000
Ontario	-	-	-
Quebec	1989-1992	18	411,000
Nova Scotia	1996	9	34,000 to 384,000
New Brunswick	1992	8	95,000
Prince Edward Island	1993-1994	5	143,000
Newfoundland	1994	6	143,000
Yukon	-	-	-
Northwest Territories	1988-1997	9	386 to 17,897
Nunavut	-	-	-

Source: Ontario Hospital Association, *Regional Health Authorities in Canada – Lessons for Ontario*, Discussion Paper, January 2002 (www.oha.com).

Table 3.2 provides information on the scope of services for which RHAs are responsible in each province/territory. The scope varies significantly. Hospital services are common to RHAs in all provinces. In addition, in some provinces, laboratory services, long-term care, home care and a variety of other health services are provided by RHAs through contracts with private not-for-profit and private for-profit organizations. RHAs in Quebec have been particularly successful in integrating a wide range of health, social and mental services. However, physician services, prescription drugs and cancer care have not been devolved to regions and continue to be administered and funded centrally by all provincial/territorial governments.

TABLE 3.2
SERVICES ADMINISTERED BY REGIONAL HEALTH AUTHORITIES

	Hospitals	Long Term Care	Home Care	Public Health	Mental Health	Rehab	Social Services	Local Ambulance	Labs
BC	X	X	X	X	X	X			X
ALTA	X	X	X	X		X			X
SASK	X	X	X	X	X	X		X	
MAN	X	X	X	X		X		X	X
QC	X	X	X	X	X	X	X	X	X
NB	X		X					X	X
NS	X			X	X	X			X
PEI	X	X	X	X	X	X	X		
NFLD	X	X	X	X	X	X	X		
NWT	X	X	X	X		X	X		X

Source: Ontario Hospital Association, *Regional Health Authorities in Canada – Lessons for Ontario*, Discussion Paper, January 2002 (www.oha.com).

RHAs differ in the degree of their decision-making authority. In some provinces, RHAs operate within specific, provincially determined administrative and fiscal constraints (Nova Scotia, Manitoba, British Columbia), while others have greater autonomy (Alberta, Saskatchewan, Prince Edward Island). Only in a few provinces do RHAs have an elected board of directors (in Alberta, for example, RHAs have a partially elected board). And only a few boards include representatives from health care providers (as in British Columbia). None has any role in raising revenue, but all are responsible for local planning, setting priorities, allocating funds and managing services for better integration and greater effectiveness and efficiency, within provincially defined policy guidelines. Many also have some direct role in delivering services, or at least employing health care providers other than physicians.

RHAs receive funding from the provincial/territorial government, usually through global budgets that are based on historical spending levels for the population served. Some jurisdictions (such as Alberta, British Columbia and Saskatchewan) have moved to needs-based per-capita funding (adjusted for population, age, sex and need indicators).

3.2 RHAs: Goals and Achievements[100]

Initially, the objectives of devolving health care decisions to the regional level were multiple. According to the Canadian literature, they included: 1) cost containment; 2) responsiveness to local needs; 3) local control of decision-making; 4) coordination and integration of services; 5) efficient use of health care resources; 6) improved access; 7) effective management; 8) greater accountability; 9) emphasis on population health and wellness; and 10) better health outcomes.

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[100] For more information, see for example the following two documents: 1) Robert Bear, "Can Medicare Be Saved? Reflections from Alberta", in *Healthcare Papers*, Summer 2000, pp. 60-67; 2) The Mazankowski report (December 2001).

There have been few evaluations of regionalization to determine the extent to which these goals have been or are now being met. However, the testimony received by the Committee and the evidence available from the literature suggest that RHAs have been very successful in many respects:

- RHAs provide health services at reduced administrative costs. For example, the Capital Health Region located in Edmonton devotes less than 3% of its total budget to administrative costs.
- RHAs have a strong focus on illness prevention and public health and ensure interactive relationships with their communities.
- RHAs are well suited to the integration and coordination of the institutions and organizations providing health services. In doing so, they deliver greater efficiencies, higher quality of service and continuous quality improvement.
- Better integration and coordination at the regional level allow for the use of the least costly providers commensurate with accessibility and quality of care goals for each individual consumer.
- Integrated health service delivery at the level of RHAs enhances the ability to respond to service demands, such as Emergency Department pressures, through integrated responses using home care, continuing care and acute care resources.
- RHAs have greater flexibility in reallocating and consolidating clinical services between health care providers and institutions.

Overall, RHAs are pivotal to the health care system, acting as intermediaries 1) between the patient and the provider, 2) between government and the local population, and 3) between the insurer (government) and the various providers. In this regard, the Committee views RHAs as key players in the reform of Canada's health care system. They offer tremendous opportunities for renewing and sustaining health care in Canada.

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3.3 Barriers that Prevent RHAs from Functioning to Their Fullest Potential[101]

During its study, the Committee learned that a number of barriers currently prevent RHAs from operating to their fullest potential. These are summarized below:

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[101] Unless otherwise indicated, the information presented in this section is based on the following documents:
The Mazankowski report (December 2001).
Glenn G. Brimacombe and Lorraine Pigeon, *A Review of the Funding Flows of Regional Health Authorities in British Columbia*, The Conference Board of Canada, 2001.
Cam Donaldson, Gillian Currie and Craig Mitton, "Integrating Canada's Disintegrated Health Care System – Lessons from Abroad", *C.D. Howe Institute Commentary*, April 2001 (www.cdhowe.org).

- While RHAs are responsible for delivering health services according to the needs of their populations, their budgets are, in some provinces, almost completely determined by government and their performance targets are set by government. In these provinces, RHAs have few options if they are unable to meet their residents' health needs within their existing financial resources. A number of observers have suggested that RHA boards must spend a great deal of their energies lobbying the province for increased funding. They have suggested that this effort would be better spent on setting their own priorities and achieving their own set of objectives rather than responding to the priorities and objectives set for them by government.

- There are weaknesses in RHAs' planning and budgeting of resources, as well as gaps in reporting performance. Currently, RHAs are required to provide business and budget plans to the province. In some cases, however, these plans are very general in nature. Specific targets are not set and agreed to by both parties, and budgets are more in the nature of guidelines rather than setting formal limits on what can be spent and for what purposes. Some analysts have suggested that agreements with the provincial government should clearly spell out what happens if RHAs do not manage to live within their budgets or do not achieve their performance targets. This would greatly improve transparency and enhance accountability.

- A useful example of how setting specific targets can be done in practice was brought to the attention of the Committee. Alberta Health and Wellness, along with Capital Health of Edmonton and Calgary Health Region, annually set target volumes for a number of province-wide services (such as organ transplants, open heart surgery, major trauma and burn care and complex neurosurgery). These targets are set based on health status, incidence of health conditions and trend data. The ability of these two Albertan RHAs to achieve the targets and the associated health outcomes are monitored annually.

- While doctors direct much of what happens in health care, they are remunerated independently of RHAs. For example, if a physician orders a laboratory test or an X-ray, it is the RHA that carries the financial burden, not the physician. David Kelly, former Assistant Deputy Minister of Health in Alberta and British Columbia, told the Committee:

Health regions have been in place now in western Canada for the better part of a decade, with a mandate and the resources to provide many publicly paid for health care services. However, to date these regions have been given virtually no responsibility for the provision of physician services. Physician payment remains a responsibility of Health Ministries, which negotiate province-wide contracts with the physicians' unions. To date, these contracts, in my opinion, have done little to assist in the integration of physician's services with regional health care services, or to promote primary care reform. A notable exception is the decision by Alberta in 1994 to move the responsibility and resources for the provision of all laboratory services, both hospital and contracted private laboratory, to

> *the health regions. This step, which moved about 10% of the physician budget to the regions, produced substantial savings and an integrated lab service at the regional level. Both the Fyke and Mazankowski reports recommend that at least part of the responsibility for the payment of physician services should move to the regions (…).*[102]

This problem could be significantly ameliorated if the cost of physician services was included in the budget of RHAs rather than having physicians paid separately by provincial/territorial governments. Perhaps more important, moving both drug therapy and primary health care to the budget of RHAs would ensure, from the patients' perspective, a fully integrated health care system (or a "seamless system"):

> *(…) the move to regional health authorities may have reduced some of the problems of uncoordinated care among organizations but it is not clear whether it has improved integration of many patient-care processes. Essential components for integrated care have been excluded from the authority of regional bodies – drugs and medical care being the most important. A regional health authority without responsibility for physicians and pharmaceuticals cannot provide integrated health care.*[103]

In light of this evidence, the Committee believes that increased responsibility for decision-making related to the full range of health services, enhanced responsibility for planning and better control over the allocation of resources would lead to greater integration of health services; these are all appropriate roles for RHAs in the publicly funded health care system today and in the future.

The Committee believes that increased responsibility for decision-making related to the full range of health services, enhanced responsibility for planning and better control over the allocation of resources would lead to greater integration of health services; these are all appropriate roles for RHAs in the publicly funded health care system today and in the future.

This requires governments to move away from "top-down" approaches and toward devolving the management and governance of health care at the regional level. The role of government should be that of overall system governance, setting policies with respect to the health of the population, negotiating strategic plans and budgets and funding RHAs to achieve their objectives.

A policy-based on some of the principles of an "internal market" approach is one potential reform that would devolve greater responsibility to RHAs, depoliticize health care decisions at the regional level, encourage more competition and more choice in the health care sector and provide Canadians with a truly seamless health care system.

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[102] David Kelly, Brief to the Committee, pp. 7-8.

[103] Peggy Leatt *et al.* (Spring 2000), p. 18.

3.4 RHAs and the Potential for Internal Markets[104]

The concept of "internal markets" may sound quite complex, but it simply refers to the introduction of market-like mechanisms into the publicly funded health care system. These market-style incentives would take place on the *delivery* and *allocation* sides of health care systems, not on the *financing* side. Internal market reforms are introduced in pursuit of efficiencies in the delivery of care and in the allocation mechanisms that distribute revenue to the health care providers and institutions.

The markets are "internal" because they involve, on both the demand and supply sides, entities within the publicly funded health care system itself. On the demand side, there is a publicly funded purchaser that operates as the agent for the population of patients being served. On the supply side, there is another entity providing the service. In this context, the purchaser would be the RHA, while the provider could be a hospital, specialist, laboratory, primary care physician, etc.

A number of observers have suggested that the Canadian health care system already involves several characteristics inherent to internal markets. For example, in most provinces RHAs purchase or contract for hospital services on behalf of their citizens. Prior to that, a global budget or some population-based funding is negotiated separately between the government and each RHA.

What has not happened yet in Canada is 1) the clear, explicit devolution of responsibility from governments to RHAs for the purchasing of the *full* range of health services; and 2) the establishment of a consistent framework of expectations, so that a variety of providers could compete for funding on a level playing field, with clear accountability, using a business or performance contract model. In some instances, RHAs currently simply pass the budget received from their provincial/territorial governments on to hospitals, based on historical spending patterns. In addition, none of the RHAs in Canada is responsible for the budget of physicians (hospital-based specialists or primary health care doctors) or for the spending on prescription drugs. As a result, there can be no competition (and no market-like behaviour) among health care providers and institutions, and no real integration of the various publicly insured health services.

Some Canadian experts contend that an internal market approach based on RHAs acting as the purchasing agents would foster effective management of health services and improve the quality of care in their regions:

> *With an internal market, regional health authorities hold the purse strings and choose between providers on the basis of quality and cost, rather than simply funding the decisions of those using the resources.*[105]

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[104] The information provided in this section is based on the following documents:
European Observatory on Health Care Systems, *Health Care Systems in Eight Countries: Trends and Challenges*, April 2002 (http://www.euro.who.int/observatory/TopPage).
Volume Three, Chapters Four and Five, January 2002.
Volume Five, April 2002.

Applying the principles of internal market reform at the regional level does not imply that hospitals currently owned by RHAs must be turned to the private sector. There is opportunity to apply the rationale behind internal market reforms in Canada through competitive contracts among the RHAs and the various public (RHA owned) hospitals. Competition can be further enhanced when private providers are allowed to compete with public providers for some publicly insured health services (such as day surgery and long term care). In addition to enhanced competition, these contracts between RHAs and their hospitals could set specific performance targets; this would greatly improve the accountability of hospitals and other health care providers.

The Committee holds the view that reforms based on internal market approaches have the potential to introduce competition among hospitals, other institutions and individual health care providers. Competition will also provides the incentives for providers to become more efficient and cost-conscious and to make decisions about what to provide, to whom, and what standard of service they can achieve.

Furthermore, the Committee believes that such reforms would ensure that RHAs have the necessary flexibility to reconfigure services in a way that is more in line with population needs. Perhaps most important, reforms based on internal market principles solve the current problem in some provinces of top-down management by provincial health departments. In addition, an internal market approach will introduce a much greater degree of transparency into the system and enhance the accountability of all parts of the system.

The Committee believes that an internal market reform can reconfigure services in a way that is more in line with population needs.

Internal market reforms involving the devolution of clear responsibility to regional health bodies have been implemented in Sweden and the United Kingdom. In Sweden, prior to reforms, hospitals were owned and operated directly by the county councils, which were responsible for financing and delivering health services and which employed most physicians, both hospital-based physicians and those providing primary health care. The reforms brought new contractual arrangements and new payment schemes.

More precisely, public hospital management was devolved from county council control to independent boards of directors. Hospital remuneration was changed to Diagnostic Related Groups (DRGs), a form of service-based funding (like the one recommended in Chapter Two of this report). Reforms of the primary health care sector were also introduced to allow county councils to purchase physician services. A number of primary health care physicians now operate privately under contract with the county councils; they are reimbursed by the county councils on a fee-for-service basis. Some other county councils have introduced capitation payments for primary health care physicians. Overall, estimates suggest that county councils in which internal market reforms were implemented were able to reduce costs by 13% over those who retained the status quo.

In the pre-reform system of the United Kingdom, hospitals were state-owned and operated by the National Health Service (NHS) through its RHAs. The budget of each

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[105] Cam Donaldson *et al.* (April 2001), p. 8.

RHA was determined by the central government and was based on a weighted capitation formula. Each hospital's budget was then determined regionally through an administrative process involving negotiations between its management and the relevant RHA. Hospital specialists were salaried employees of the NHS. A major critique of the system was that RHAs were purchasing services on behalf of their local populations, but at the same time they were running the local hospitals. Thus, they had a pronounced conflict of interest aimed at protecting those hospitals.

When internal market reforms were introduced, RHAs ceased to manage their own hospitals directly and became responsible, as purchasing organizations, for contracting with NHS hospitals and private providers to deliver the services required by their resident populations. Hospitals, for their part, were transformed into NHS Trusts: that is, not-for-profit organizations within the NHS but outside the direct ownership of RHAs. A system of DRGs was developed for providing payment to hospitals.

A review of the literature suggests that there has been little rigorous evaluation of the role of RHAs as purchasers of care in the United Kingdom. The fact that all RHAs became purchasers at the beginning of the reforms meant that there was little scope for comparative analysis. According to some experts, the internal markets did not function as originally envisaged because of a lack of incentive on both sides of the market to make restructuring work.

Perhaps more important, responsibility for primary health care was never devolved to RHAs. Primary health care physicians were encouraged to establish GP Fundholding practices. GP Fundholders were given a fund to purchase, on behalf of their patients, prescription drugs, hospital-based physician services and some hospital care. As such, most primary health care physicians practising as GP Fundholders became rival purchasers to RHAs. In fact, the GP Fundholding system became so popular that the central government decided to pass purchasing responsibilities from RHAs to GP Fundholders (which later became Primary Care Trusts).

According to Donaldson, Currie and Mitton (2001), the potential for turning RHAs into purchasers exists in Canada. RHAs now exist in most provinces/territories and the fact that most of Canada's health care is consumed in and around large cities allows, in their view, for plenty of potential competition among providers. They stress, however, that there are challenges to overcome.

- First, the method of remunerating hospitals would have to change if market-like incentives were to work. That is, hospitals would have to be remunerated according to service-based funding. This is one of the reasons why the Committee has recommended service-based funding in Chapter Two.

- Second, if hospitals were to commit to contracts established with RHAs, more control would have to be exerted by hospitals over those who work in them. Ultimately, this would require that responsibility for the budget of hospital-based specialists be devolved to RHAs.

- Third, to achieve a fully integrated or ("seamless") health care system, the budget for primary health care physicians would have to be allocated to

RHAs for contracting with physicians in their region. Physicians or groups of physicians should be able to choose the option of entering into contracts with RHAs or working outside the system. This would require a revision of the current mode for remunerating doctors.

- And fourth, serious consideration should be given to devolving authority for spending on prescription drugs to RHAs.

According to the Mazankowski report, RHAs are ready to take up these challenges. More precisely, the report stated:

- RHAs should consider establishing contracts with hospitals in their region as well as alternative ownership arrangements and payment mechanisms.
- RHAs should be encouraged to contract with a variety of providers including clinics, private and not-for-profit providers, groups of health care providers (including primary health care physicians) and other regions.
- RHAs should be encouraged to foster the development of centres of specialization. RHAs with specialized expertise should be able to market those services to other regions and enter into contracts with other regions to deliver services. In this way, regions would generate a sufficient volume of services to allow them to achieve better outcomes.

The Committee acknowledges the fact that, while internal markets can improve efficiency in large urban centres and populated areas, they cannot work properly in regions with a low population density. This point was also raised by Michael Decter, currently Chair of CIHI's Board of Directors and formerly Deputy Minister of Health in Ontario, when he stated:

> *(…) population density is underrated as a factor in the ability to implement an internal market. It is one of the hazards of the European experience brought to Canada. Purchaser/provider splits work well where you have enough density of population and enough density of providers to have some competition.*
>
> *(…) We have two realities in Canada. We have a good portion of the population, perhaps 70 percent, living in a handful of big cities where I think this model can work. The competition could be virtuous in terms of driving a better price and quality over time. In the rest of it, you need strategies to have enough service there to meet the needs. It is not a matter of competition. It is more a matter of stability of funding and strategies to allow providers to actually locate.*[106]

The Committee also acknowledges that there are currently no RHAs in Ontario, the Yukon and Nunavut. Accordingly, reforms based on internal markets with RHAs having responsibility for the full range of health services would not be possible in these jurisdictions. Alternatives approaches to integrating health service delivery and improving efficiency will therefore need to be considered.

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[106] Michael Decter (52:12).

3.5 Committee Commentary

The Committee strongly believes that now is the time for RHAs to be given greater control over the full range of health care spending in their region.

The Committee believes that the devolution of further responsibility to regional health authorities is an important step in reforming health care in Canada. In fact, RHAs exist in most provinces and a large percentage of health care spending occurs in and around large cities, creating the potential for competition among the various providers and institutions. We strongly believe that now is the time for RHAs to be given greater control over the *full* range of health care spending in their region.

The Committee acknowledges that establishing market-style incentives among health care institutions requires sufficient numbers of providers and a significant population base. Thus, while a number of regions across Canada would be capable of undertaking internal market reforms, some of the smaller provinces and some regions within the larger ones would be unable to do so. In our view, internal market reforms should be done in those geographic locations where gains can be achieved in terms of effectiveness and efficiency.

The Committee also believes that a reform based on the principle of internal markets is the solution to the various barriers that prevent RHAs from operating to their fullest potential. On the one hand, political interference will be minimized when RHAs are given the freedom and responsibility for achieving targets and performance standards. On the other hand, RHAs will have the needed flexibility to allocate their financial resources more cost-effectively and more in line with the needs of the population they serve. In addition, bringing the primary health care envelope under the authority of the RHAs will ensure that they have the levers to exercise more control over these costs. Moreover, devolution of financial responsibility for hospital services, hospital-based physicians and primary health care will encourage competition and allow RHAs to deliver/contract for the most efficient and timely services. Finally, assuming responsibility for the full range of health services will result in a better integrated and more patient-oriented health care system.

The Committee acknowledges that the introduction of internal market principles within the publicly funded health care system requires changing the method of remunerating hospitals. We believe that service-based funding is the most appropriate method, and our recommendation to that effect is detailed in Chapter Two.

Despite the fact that the management and delivery of health services is an "intensively provincial matter", the Committee is of the view that the federal government can play an important role in improving health care delivery at the regional level through its sustained investment into the health care info-structure, the evaluation of health care system outcomes and the supply of human resources in health care.

The Committee is also aware that, in order to be successful, internal market reforms require detailed and reliable costing information. We also believe that the recommendations we make in relation to the full deployment of a national system of electronic health records, along with an independent evaluation of performance and outcomes (see Chapter Ten), will greatly facilitate such reform.

We understand that there have been few, if any, rigorous assessments of the internal market reforms undertaken in other countries. We believe that the influence of many factors, such as introducing different reforms simultaneously, has made it difficult to isolate the impact of the internal market reforms undertaken elsewhere. For this reason, the Committee feels it is important to monitor and evaluate the impact that reforms based on internal market principles can have in Canada on productivity, health outcomes, access to publicly insured services, waiting times, etc., and to report this information to Canadians.

Despite the fact that the management and delivery of health services is an "intensively provincial matter," the Committee is of the view that the federal government can play an important role in improving health care delivery at the regional level through its sustained investment into health care info-structure (particularly the development of the information systems that make it possible to move to service-based funding for hospitals), the evaluation of health care system outcomes, and the supply of human resources in health care (each of these issues is addressed in subsequent chapters of this report).

Therefore, the Committee recommends that:

Regional health authorities in major urban centres be given control over the cost of physician services in addition to their responsibility for hospital services in their regions. Authority for prescription drug spending should also be devolved to RHAs.

Regional health authorities should be able to choose between providers (individual or institutional) on the basis of quality and costs, and to reward the best providers with increased volume. As such, RHAs should establish clear contracts specifying volume of services and performance targets.

The federal government should encourage the devolution of responsibility from provincial/territorial governments to regional health authorities, and participate in evaluating the impact of internal market reforms undertaken at the regional level.

CHAPTER FOUR

PRIMARY HEALTH CARE REFORM

4.1 Why is Primary Health Care Reform Needed?

Primary health care constitutes a patient's first point of contact with the health care system. According to the Canadian Medical Association, "primary medical care includes the diagnosis, treatment and management of health problems; prevention and health promotion; and ongoing support, with family and community intervention where needed."[107]

At present, primary care delivery in Canada is organized mainly around family physicians and general practitioners working solo or in small group practices. Approximately one-third of primary care physicians work alone and fewer than 10 percent work in multidisciplinary practices. The vast majority of primary care practices are owned and managed by physicians. Fee-for-service (FFS) payment is the dominant form of physician remuneration.

A variety of weaknesses and problems with the way in which primary care is generally delivered in Canada have been noted. These include:

- fragmentation of care and services;
- inefficient use of health care providers;
- lack of emphasis on health promotion;
- barriers to access (care not available after hours and on weekends);
- poor information sharing, collection, and management;
- misalignment of incentives, especially fee-for-service remuneration that rewards episodic more than continuing care and health promotion/disease prevention.[108]

A fairly wide consensus is emerging that the creation of primary care groups (PCGs) is central to reform of primary care delivery, and just about every major provincial report issued in recent years has recommended some version of primary care reform (see section 4.2.1). As Michael Decter, former Deputy Minister of Health in Ontario, told the Committee:

> ***There is a fairly wide consensus emerging that the creation of primary care groups (PCGs) is central to reform of primary care delivery, and just about every major provincial report issued in recent years has recommended some version of primary care reform.***

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[107] Cited in Ann L. Mable and John Marriott, *Health Transition Fund Synthesis Series – Primary Health Care*, June 2002, p. 1.

[108] *Ibid.*, p. 2.

The single biggest thing is to move from a model that cannot really work any more — which is solo practice — to groups. Those groups could have many configurations.[109]

Primary care groups are practices composed of several physicians; they can also incorporate other health care professionals (potentially including nurses, nurse practitioners, physiotherapists, dieticians, midwives, psychologists, etc.).

In nearly all existing models of primary care groups, patients have to enrol with a specific group or physician within a defined group for a definite period of time. The PCG is then responsible for ensuring access to primary care for enrolled (rostered) patients 24 hours a day, seven days a week. Once enrolled, patients are expected to remain with their designated primary health care group for a specific period, usually six months to a year, unless they change their place of residence. The primary care physician or team acts as the gatekeeper to the rest of the health care system, referring enrolled patients to specialists. As now, the choice of specialist would be negotiated with the patient, by the primary care physician concerned . However, the rostered patient would not have direct access to a specialist (as is, in theory, the case now) or to other family physicians outside the group, except, of course, in urgent situations.

There are several potential advantages to a system based on PCGs, including:

- Guaranteed patient access on a 24/7 basis to the patient's own *team* of doctors and other providers;
- Better utilization of the spectrum of health care providers, and better coordination of patient services, through interdisciplinary teamwork;
- Potential cost savings in the longer term by reducing demand on expensive emergency rooms and specialists' services and by making sure that the most appropriately qualified professional handles each task;
- Provision of health promotion and illness prevention measures to patients.

In Volume Five, the Committee accepted the need for diversity in the models of primary care groups appropriate for the many and diverse regions and provinces of the country. The Committee drew on the various reports (see section 4.2.1) to establish a list of desirable attributes for all models of multi-disciplinary primary health care teams, including:

- The provision of a comprehensive range of services, 24 hours a day, seven days a week;
- Delivery of services by the most appropriately qualified health care professional;
- Adoption of alternative methods of funding to fee-for-service, such as capitation, either exclusively or as part of blended funding formulae;
- Integration of health promotion and illness prevention strategies in the teams' day-to-day work.

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[109] 52:9

- Full integration of electronic patient health records into the delivery of care.

One issue that surfaced during the Committee's most recent hearings was whether primary care reform would lead to noticeable cost savings. Some witnesses suggested that, because PCGs allow for all providers to practise to the full extent of their scope of practice, it should be possible to save money by having the most appropriately qualified provider deliver each service. These witnesses saw a potential source of savings in the fact that, for example, up to 60-70% of the procedures performed by physicians could be done by nurses or nurse practitioners (nurses with advanced qualifications). They felt that two things could be accomplished by transferring these tasks to other qualified personnel who are not as highly paid as physicians: money could be saved in the short term, and physicians would also be able devote a greater proportion of their time to those tasks for which only they are qualified, many of which are now referred to specialists because primary care physicians lack the time to do them.[110]

While all witnesses agreed that there would be efficiency gains by allowing physicians to concentrate on the full range of procedures where their particular training and skills were required, several witnesses questioned whether the anticipated cost savings would in fact be generated. For example, Dr. Peter Barrett, former president of the CMA, noted that:

> *expanding the primary care team to include nurses, pharmacists, dieticians and others, while desirable, will cost the system more, not less. Therefore, we need to change our way of thinking about primary care reform. We must think of this as an investment, not in terms of cost savings but as a cost effective way to meet the emerging, unmet needs of ..Canadians.*[111]

At the same time, the Committee feels that there would be factors that would indeed operate to reduce costs. Dr. Barrett's comment is based on the assumption that there is a large amount of unmet need which, as a result of primary care reform, would be filled because more health care professionals will be supplying more services. Under a fee-for-service arrangement, this would obviously cost more money. At the same time, however, if primary care physicians provide services through the full range of their competency, there would also be a decrease in referrals to specialists.[112]

However all witnesses argued that even if there were no short-term cost savings, the importance of primary care reform was not diminished. Rather, the discussion brought to the fore other reasons for pushing it forward. In the words of Professor Brian Hutchison of McMaster University:

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[110] This point is well illustrated by the following facts from a 1999 report of the Ontario Health Services Restructuring Commission, cited in Volume Four of the Committee's study (p. 110). One third of billings by specialists in Ontario in 1997 (at a total cost of $1.4 billion) was work that could have been done by family doctors. The five most frequently used billing codes by Ontario family doctors in 1997, which account for about 69% of the total amount billed by these doctors (at a cost of $1.2 billion), were for: intermediate assessments (well baby care), general assessments, minor assessments, individual psychotherapy, and counselling. The clinical consultants to the Ontario Health Services Restructuring Commission were of the opinion that most, if not all of the services these bills represent could well be provided by nurse practitioners, nurses and many well-trained health professionals.

[111] 56:12

[112] Research done for the Ontario Health Services Restructuring Commission shows that the most dramatic decrease in referrals would be to dermatologists and ear-nose-and-throat specialists.

> *The emphasis on cost control has led to a focus on nurse practitioners as substitutes for physicians. The other dimension that needs to be explored is their potential for broadening the scope of primary care and providing a greater emphasis on health promotion, prevention and health counselling, where they have a great deal to offer, probably more than physicians. We should think of nurse practitioners in a complementary role, not mainly with the idea of saving money. We should view them in terms of improving health.*[113]

The Committee strongly endorses this point of view. Indeed, the synthesis report on various primary health care projects undertaken under the auspices of Health Canada's Health Transition Fund provides further evidence in this direction. Discussing a project that evaluated the role of a nurse practitioner in the context of a multidisciplinary team working out of a Calgary clinic, the report says:

> *Although the physicians were not initially clear on the role of the nurse practitioner, the project soon saw nurse practitioners facilitating communication among various providers, "significantly" increasing access to care, improving quality, and handling cases, thus allowing physicians to spend more time with patients who required their services; 95 per cent of patients were satisfied with the initiative.*[114]

4.2 The Provinces and Primary Care Reform

In this section, we review briefly the highlights of six provincial reports that contain recommendations for primary care reform. We then look at recent implementation initiatives in three provinces, Ontario, Quebec and New Brunswick, that have progressed beyond report-writing and pilot projects.

4.2.1 Recent reports

Table 4.1 (end of chapter) presents an overview of the different proposals contained in six reports released since late 1999,[115] organized according to a number of key elements of primary care reform. All six contain many important similarities and a number of significant differences.

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[113] 58:13

[114] Marriott Mable, *op cit.*, p. 20

[115] These reports are:

1. Health Services Restructuring Commission (Duncan Sinclair, Chair), *Primary Health Care Strategy – Advice and Recommendations to the Honourable Elizabeth Witmer, Minister of Health*, Government of Ontario, December 1999.
2. Commission d'étude sur les services de santé et les services sociaux (Michel Clair, Commissioner), *Emerging Solutions – Report and Recommendations*, January 2001
3. Saskatchewan Commission on Medicare (Kenneth Fyke, commissioner), *Caring for Medicare – Sustaining a Quality System*, April 2001
4. Premier's Advisory Council on Health (Right Hon. Don Mazankowski, Chair), *A Framework for Reform*, report to the Premier of Alberta, December 2001, pp. 52-53.
5. Primary Care Advisory Committee (Kathy LeGrow, Chair), *The Family Physician's Role in a Continuum of Care Framework for Newfoundland and Labrador*, A Framework for Primary Care Renewal, Department of Health and Community Services, Newfoundland and Labrador, December 2001.
6. Report from the Premier's Health Quality Council, *Health Renewal*, Government of New Brunswick, January 2002.

All of the reports advocated the delivery of comprehensive primary care through some form of multidisciplinary team, usually 24 hours a day, seven days a week. However, the means suggested for achieving this objective varied considerably, as did the detail provided in the various reports. It is important to note that all stressed the need for the introduction of some form of Electronic Health Record (EHR – see Chapter Ten), although not all linked this need directly to their proposals for primary care reform.

The reports differed in their descriptions of the multi-disciplinary teams, and in the ways in which they envisaged the connections between primary care groups and other health care providers such as hospitals. Only a minority of the reports advocated specific alternate funding mechanisms, and only two presented explicit proposals for rostering.

Although it is too early to say whether the recommendations of these various reports will be implemented, the Ontario example is perhaps instructive. The Health Services Restructuring Commission (Sinclair) Report was both the first to be issued and contained the most detailed outline of how primary care reform should be carried out. As Ontario became the first to begin implementation of a province-wide scheme for primary care reform it is interesting to note that the actual model being put in place appears to be less uniform, as well as more flexible and voluntary than the plan contained in the report.

4.2.2 The Ontario Family Health Network

The Ontario Family Health Network (OFHN) was created in March 2001 as a semi-arm's-length agency that reports to the Ontario Ministry of Health and Long-Term Care (MOHLTC). The OFHN provides family physicians with information, administrative support and technology funding to support the voluntary creation of Family Health Networks (FHNs) in their communities.

The FHN model encourages groups of family doctors and allied health professionals, such as nurse practitioners, to work together to provide accessible, co-ordinated care to patients enrolled with them. OFHN provides funding, guidelines and support, but doctors voluntarily decide to form a local FHN and plan how they will work together to best serve their patients.

A minimum of five physicians (one of whom must act as group leader) and 4,000 enrolled patients are required to form an FHN, which can be spread over more than one site. In addition to regular office hours, one FHN office must be open from 5 p.m. to 8 p.m. Monday to Thursday, and three hours each day on the weekend. After hours, rostered patients have access to a phone line staffed by nurses, with support from a FHN doctor on call.

Pilots, known as Primary Care Networks, were created in 1998. Between 1998 and 2000, 14 pilot networks were created in seven communities, today embracing more than 178 physicians and approximately 270,000 enrolled patients. In November 2001, the Ontario Medical Association (OMA) voted to allow the OFHN to begin offering Family Health Network agreements to doctors in northern and rural Ontario. In January 2002, the OMA voted to allow a general contract agreement to be released to family doctors throughout the province. In May 2002, a group of six doctors from the Dorval Medical Associates in Oakville formed the province's first Family Health Network.

Patients who sign on to an FHN agree to contact their Family Health Network doctor first when they need a health service, unless they are travelling or in an emergency situation. They also agree to allow the Ministry of Health and Long-Term Care to provide to the FHN doctor some information about health services received by the patients from family physicians outside their network. In addition, the MOHLTC can release to the Family Health Network doctor dates of immunizations, cervical screenings and mammograms.

Referrals to specialists, or to other family physicians for second opinions, is done by the Family Health Network physician in consultation with each patient. Patients can continue to use the services of their doctor without joining that doctor's FHN. Similarly, if they decide to cancel their enrolment in their doctor's FHN, they do not have to change family doctors. He or she can continue to see that doctor on the same basis as before they joined the network. Patients are free to change the doctor with whom they are enrolled up to twice a year. If, however, they are seeing another general practitioner on a regular basis, the doctor with whom they are enrolled can remove them from his or her Family Health Network roster of patients.

Physician satisfaction has been high and, to date, no physicians have left the pilot networks. The agreements that physicians sign in order to create an FHN address patient and physician rights and responsibilities, physician compensation, and administrative support.

Payment for rostered patients - which is weighted by age and gender (see Table 4.2) and covers a basket of 57 common primary care services - is expected to amount to about 60% of FHN revenue. There are additional payments for providing preventive health services such as vaccinations, Pap smears and mammography; bonuses for repatriating patients who previously saw other physicians for any of the core primary care services; an on-call fee; and premiums for non-core services such as deliveries and hospital in-patient care.

TABLE 4.2
RATIO FOR PAYMENT OF BASE RATE PAYMENT AND SPECIAL PAYMENT BY AGE AND SEX

Age	Male	Female	Average
00-04	1.05	1.00	1.03
05-09	0.55	0.54	0.55
10-14	0.44	0.46	0.45
15-19	0.46	0.82	0.64
20-24	0.46	1.03	0.74
25-29	0.50	1.07	0.79
30-34	0.58	1.08	0.83
35-39	0.72	1.17	0.95

Age	Male	Female	Average
40-44	0.80	1.20	1.01
45-49	0.88	1.30	1.11
50-54	1.02	1.46	1.25
55-59	1.16	1.47	1.33
60-64	1.27	1.50	1.40
65-69	1.43	1.58	1.52
70-74	1.66	1.69	1.69
75-79	1.99	2.01	2.00
80-84	2.08	2.08	2.08
85-89	2.34	2.37	2.36
90+	2.64	2.68	2.67

Note: $96.85 is the multiplier for the base rate payment.
Source: Matt Borsellino, "Primary Care Payment Options Become Available," *The Medical Post*, 4 December 2001, p. 8.

Physicians can also bill for continuing medical education, and each network is entitled to up to $25,000 annually to defray additional administration costs. FHNs are also eligible for funding to set up an information technology system, including electronic patient records, drug interaction alerts, tracking of preventive care measures and electronic billing.

A physician who does an "average" amount of office work, hospital, obstetrics and ER, with a roster size of 1,480, patients might be paid $254,846 under the blended model. For a physician who only does office work and has a roster size of 1,423 patients, the annual payment might be $204,256. For a roster of only 598 patients, gross payment is $105,455.

Dr. Elliot Halparin, a Georgetown, Ont., family physician and President of the OMA, said average payment under the blended model of the urban FHN template is an estimated $244,500, assuming a roster size of 1,600 patients. This compares with $210,700 under traditional fee-for-service. The numbers are based on the average billings of the 6,500 to 7,000 Ontario family physicians who provide comprehensive care.

While it is too early to attempt any evaluation of the actual OFHN project, an assessment of the pilot projects (Primary Care Networks or PCNs) that preceded the full rollout was done by PriceWaterhouseCoopers for the MOHLTC in October 2001. Some of the conclusions are worth noting:

- The top five benefits physicians have experienced in being part of a PCN are: the lifestyle and practice-style benefits of the capitation model; better care for patients; information technology (IT); increased income; shared call and coverage for absences.
- The top challenges physicians have faced in being part of a PCN are: administrative demands; IT; patient rostering; dealing with the Ministry.

- To date, the involvement of nurse practitioners and other health care providers in the networks has been limited, although patients report very high satisfaction with nurse practitioners.
- Role definition and team integration have been challenges in integrating nurse practitioners into PCNs; the nurse practitioner to physician ratio extremely low in many PCNs.
- It has been proposed that nurse practitioners might have an impact on cost-effectiveness, but there is no definitive evidence on the economic impact of nurse practitioners in the PCNs.
- There is high physician satisfaction with capitation, and preliminary evidence of changed behaviours due to capitation incentives.
- The teletriage service appears to have had a positive impact on emergency room utilization. Data from the teletriage service provider suggests that in the absence of the teletriage service, callers would have made 1,874 visits to hospital emergency rooms. However, the teletriage service advised only 871 callers to seek emergency care – a difference of 1,003 visits.

The report also noted three categories of barriers that impede the progress of the networks:

- *Implementation barriers.* Examples include delays in various IT components, insufficient multidisciplinary resources, inability to respond to higher than anticipated teletriage call volumes, and insufficient patient and public education about the reform.
- *Model barriers.* Examples include a physician-centric approach to the reform, issues with the bonus codes and capitation rates, insufficient feedback to physicians on outside use, and the need for specific performance measures for the PCNs.
- *Systemic barriers.* Examples include physician shortages, the health care funding structure, lack of integration with reforms in other health sectors and gaps in service.

The Committee feels it is important to note that the model adopted in Ontario differs considerably from that advocated by the Hospital Restructuring Commission. The Commission had wanted governments to stop paying for individual services performed by physicians and move to a model in which the PCG as a whole would be funded primarily using capitation. In the Committee's view this proposal would have led to the creation of genuine group practices, instead of the kind of practice that seems to be emerging in Ontario, where practitioners who remain essentially independent work together under a single roof. The Committee agrees with the approach recommended by the Hospital Restructuring Commission.

However, two other provinces recently announced initiatives in primary care reform that more closely resemble the recommendations of the reports that had been commissioned in their respective jurisdictions.

4.2.3 Quebec

On June 4, 2002, the Quebec Minister of Health and the President of the Quebec Federation of General Practitioners announced that they had reached agreement on arrangements for establishing the first 20 family medicine groups (FMGs). This is part of a plan to create over 300 of these groups over the next four years, by which point, as recommended by the Clair Commission, they are expected to provide primary care service to 75% of the province's population.[116]

The creation of FMGs is voluntary, as is patient enrolment. Each FMG will involve 6 to 10 physicians and nurses and provide a full complement of primary care services to 10-20,000 patients.[117] During an initial transitional phase, physicians will continue to be remunerated for clinical activity in the same way as now (fee-for-service, salary, etc.), but will also receive payment on an hourly basis for activities associated with the operation of the FMG, such as the coordination of services for enrolled patients, or interdisciplinary collaboration with other providers, as well as a yearly premium for each patient on their roster.[118]

Patients enrol with the doctor of their choice within a given FMG. Enrolment lasts a year and is automatically renewed unless the patient cancels in writing. Patients agree to consult their doctor (or someone else from the FMG) first, unless it is an emergency or they are travelling. FMGs are open for extended hours and guarantee service 24/7 using telephone emergency service.[119]

The Quebec government has committed $15 million to finance the creation of the first 20 FMGs, split three ways: $5 million for additional physician compensation; $5 million for office computerization and equipment; $5 million to hire nurses.[120] Each FMG must be approved by the Minister and must have in place a contract with a local CLSC (community health centre) as well as an agreement with the regional health board.

The Quebec government also recently introduced legislation, jointly sponsored by the health and justice ministries, that redefines the role of physicians, allowing them to delegate more duties to nurses. Nurses will specialize in areas such as surgery, cardiology and neo-natal intensive care, as well as performing extra tasks in a variety of settings, including in emergency rooms.[121]

4.2.4 New Brunswick

The Government of New Brunswick recently announced two related measures that follow up on the recommendations on primary care reform contained in the Premier's Health Quality Council Report. On May 8, 2002 the government brought down legislation intended to introduce nurse practitioners to the province's health system and allow registered nurses to make greater use of their skills and training. The legislation will provide for the creation and registration of nurse practitioners, and will also enable front-line nurses working in primary care to deal with certain non-urgent conditions on their own, without the direct intervention of a physician.[122] They will be able to order laboratory tests and a variety of diagnostic procedures and also to issue prescriptions for some drugs.

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[116] Ministère de la Santé et des Services sociaux (MSSS) press release, June 4, 2002.

[117] *Health Edition*, Vol. 6 No. 23, June 7, 2002, p. 4

[118] MSSS fiche technique, « Résumé de l'entente particulière entre la FMOQ et le MSSS relative aux groupes de médecine de famille. »

[119] MSSS fiche technique, "Le groupe de médecine de famille."

[120] *Health Edition*, op. cit.

[121] *Medical Post*, May 14, 2002.

The Minister of Health also announced that the government will spend $2.1 million to establish at least two community health centres in the province during the current fiscal year.[123] These centres will use multidisciplinary teams of health professionals, including nurse practitioners.

Both physician and nurses' organizations have been supportive. In fact, in April 2002 the New Brunswick Medical Society had proposed that some nursing services be billed directly to Medicare so that both physicians and nurses could see patients. It reasoned that this would allow family physician practices to take on more patients, shorten waiting lists for specialists and even attract some nurses back to the profession.

4.3 Overcoming the Barriers to Change

The Committee welcomes these provincial initiatives. We note that, for the first time, they move primary health care reform off the drawing board and into the realm of concrete application. These developments therefore offer grounds for guarded optimism that significant reform of primary care delivery is possible in Canada. However, there remain a number of barriers to change that must be overcome.

For example, with respect to Ontario, a number of witnesses expressed concern over the "physician-centric" nature of the OFHN. One of these, Professor Hutchison, told the Committee that the Ontario model was:

> *…a very limited model that reflects the process by which it was negotiated — bilateral negotiations between the government and the Ontario Medical Association. There were no non-physician stakeholders involved in the discussion. It was a private, "behind closed doors" set of negotiations.*
>
> *Although it has interesting elements, it is a pretty traditional approach. It changes funding (physician payment) methodology, but it does not change a lot of other things. It certainly does not provide many opportunities for providers to develop and evaluate varying arrangements that involve non-physician providers such as nurse practitioners, social workers, midwives, and so on. It is a physician-centred model.*[124]

Reinforcing that, Dr. Peter Barrett insisted that "to ensure comprehensive and integrated family care, family physicians should remain as the central provider and coordinator of timely access to publicly-funded medical services."[125] Dr. Ruth Wilson, the Chair of the OFHN, acknowledged in her testimony that the current Ontario model was a starting point, and that she was "expecting and hoping the relationships with other professionals will grow as we put family health networks in place,"[126] adding that "we have a large process of change to introduce if we are to convince the thousands of family physicians in Ontario to accept this model."[127]

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[122] News Release 453, May 8, 2002.

[123] *Medical Post*, Vol. 38 No. 21, May 21, 2002.

[124] 58:23

In this regard, the President of the OMA, Dr. Elliott Halparin, noted that it will take time before physicians sign on in large numbers:

> *I think it will be a bit like popping popcorn: A few kernels will pop to begin with, but then there will be a lot of popping going on when people understand that this acknowledges the complexities involved in providing comprehensive care, that it is good for patients and, by extension, good for physicians.*[128]

More generally, witnesses pointed to the continued presence of a variety of barriers to the implementation of primary care reform. These include:

- The vested interests of various professional groups
- Shortages of qualified personnel
- Fee-for-service as the dominant method of physician remuneration
- High start-up costs
- The absence of electronic information infrastructure

The issue that seemed to spark the most controversy among the Committee's witnesses was the first. Some felt that strong action, by government if necessary, was needed to break the log-jam with regard to professional groups protecting their respective turfs. Claude Forget, former Minister of Health in Quebec, argued that the "sector is not unlike a medieval guild system in the sense that it is rigid and does not allow the use of someone from another related profession if you find that you are in a deficit situation, and move him or her over."[129]

Graham Scott, former Deputy Minister of Health in Ontario, expressed a similar view, pointing out that "we have a very well-funded, well-organized, and powerful monster in the form of each one of these health professional organizations,"[130] and that "the eventual threatened hammer of forced legislation"[131] was required to bring the parties to the table in order to revise the existing regulation of scopes of practice.

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[125] 56:10
[126] 57:7
[127] 57:17
[128] 56:22
[129] 53:54
[130] 53:47
[131] 53:49

Other witnesses, however, stressed that primary care reform could not be imposed upon health care providers, but will work only if adopted voluntarily. Dr. Les Vertesi, Medical Director at the Royal Columbian Hospital in Vancouver, argued that "there are some things such as primary health care reform that have to be done by the providers because the detail is incredibly important."[132] And Professor Hutchison noted that, "the chances of imposing reforms on unwilling providers are very small, partly because I do not think the public sees primary care reform as offering huge advantages to them."[133]

With regard to scopes of practice, Ms. Kelly Kay, of the Canadian Practical Nurses Association, noted that:

> *[the fact that] Licensed Practical Nurses continue to experience artificial limits to practice, that nurse practitioners must struggle for recognition and remuneration and that other professionals such as physiotherapists still face restrictions to direct access are examples that speak to continuing barriers imposed upon professional groups.*[134]

At the same time, physician representatives noted the progress that had been made among professional organizations in agreeing to common principles for determining scopes of practice. Dr. Barrett pointed out that:

> *The Canadian Medical Association had developed a "scopes of practice" policy that clearly supports a collaborative and cooperative approach, which has been supported in principle by the Canadian Nurses Association and the Canadian Pharmacists Association. We indeed have a signed document to that effect.*[135]

In Volume Five, the Committee expressed its support for the revision of scope of practice rules in order to allow all health care providers to deliver the full range of services for which they have been trained.[136] In the Committee's view, these should be as standardized as possible across the country. The synthesis report of the Health Transition Fund's primary care projects reached a similar conclusion, notably with regard to nurse practitioners:

...the Committee expressed its support for the revision of scope of practice rules in order to allow all health care providers to deliver the full range of services for which they have been trained. In the Committee's view, these should be as standardized as possible across the country.

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[132] 53:90

[133] 58:12

[134] 61:4

[135] 56:12

[136] See also Chapter Eleven for additional comments on the need to reform scope of practice rules.

> *A federal/provincial/territorial initiative should develop national standards for terminology and scope of practice. It should include legislative requirements that support an expanded role for nurses and nurse practitioners.*[137]

The Committee endorses this conclusion and believes that the federal government should take the initiative in this regard.

Some witnesses suggested that the key ingredient lacking in order to make more rapid progress in implementing primary care reform is political will. In this vein, Michael Decter told the Committee:

> *It is not about the right model; it is about moving the yardsticks. We have spent a long time looking for the perfect model for primary care reform. It has worked in some places largely because someone just had the will to do it.*[138]

Witnesses reiterated the point made by the Committee in Volume Five that no single model could be applied in the same fashion in all parts of the country. Kelly Kay stated, "primary health care service delivery will look different in each community" since "communities must customize primary health care services in response to their own identified needs."[139] For her part, Dr. Susan Hutchison, Chair of the GP Forum of the Canadian Medical Association, told the Committee:

> *The mix of health care providers varies based on the needs of the population. There is no ideal mix. What works best is an adequate human resource to meet the needs of the population. The mix of providers is dictated by the services required to address these patient needs. The ideal range of services for a given team would depend on the needs of the population and the available mix of providers. There may be considerable variability between the needs of a given population, as is the case in Aboriginal populations, for example.*[140]

The Synthesis Report on Health Transition Fund projects in primary care (June 2002), reached a similar conclusion, noting that "the health system has already demonstrated its capacity and ability to support organizational variations and could continue to do this within an overarching theme of primary health care integration."[141] It also drew a number of lessons that coincide with the recommendations made by the Committee in Volume Five, both with respect to the basic features a reformed primary care system should have, and to developing a national health human resources strategy and implementing a national electronic health record. In particular, it concluded:

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[137] Marriott Mable, *op. cit.*, p. 29.

[138] 52:16

[139] 61:5

[140] 56:15

[141] Marriott Mable, *op. cit.*, p. 24

> *The first-hand experience gained through the* HTF *projects offers new insights and reinforces long-standing knowledge about aspects of primary health care: the benefits of group practices and multidisciplinary teams; the untapped potential of nurses; and the linkages between determinants, health promotion and disease, and injury prevention.*[142]

The report also insisted that certain conditions were necessary to the success of primary care reform, arguing that "the development of a common electronic health record and access to computers and other technology for services, information, and research is essential to successful primary health care."[143]

4.4 The Federal Role

In Volume Five the Committee recommended that:

> **The federal government continue to work with the provinces and territories to reform primary care delivery, and that it provide ongoing financial support for reform initiatives that lead to the creation of multi-disciplinary primary health care teams that:**
>
> - **are working to provide a broad range of services, 24 hours a day, 7 days a week;**
> - **strive to ensure that services are delivered by the most appropriately qualified health care professional;**
> - **utilise to the fullest the skills and competencies of a diversity of health care professionals;**
> - **adopt alternative methods of funding to fee-for-service, such as capitation, either exclusively or as part of blended funding formulae;**
> - **seek to integrate health promotion and illness prevention strategies in their day-to-day work;**
> - **progressively assume a greater degree of responsibility for all the health and wellness needs of the population they serve.**

Ongoing financial support for reform initiatives that lead to the creation of multidisciplinary primary health care teams would represent a continuation of the commitment to primary care reform that the federal government displayed in funding the $150 million Health Transition Fund, of which over $60 million was spent on projects related to primary care reform. The federal government also committed $560 million out of the $800-million Primary Health Care Transition Fund (PHCTF) that was created as a result of the First Ministers Conference in 2000 to assist the provinces and territories in broadening and accelerating primary health care initiatives. This money is to be allocated on a per capita basis. To access these funds, each provincial and territorial government must develop one proposal showing how their PHCTF funding will support the transitional costs associated with primary health care reform.

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[142] *Ibid.*

[143] *Ibid.*, p.25

However, the PHCTF is not an ongoing program. The Committee recognizes that the start-up costs for primary care groups can be substantial. Based on the actual costs of implementing primary care reform in Quebec, this cost could be as much as $750,000 per group, while earlier estimates from Quebec had placed this cost as high as $1 million per group.

The Committee therefore recommends that:

The federal government commit $50 million per year of the new revenue the Committee has recommended it raise to assist the provinces in setting up primary care groups.

This money would be in addition to any funds made available through the PHCTF and should enable the creation of between 50 and 65 primary care groups per year.

In order for primary care groups to function effectively, the Committee is convinced that they must act as gatekeepers to the rest of the health care system. For example, patients who are enrolled in a particular PCG must have incentives, both positive and negative, to ensure that they consult their PCG physician rather than seek care from specialists on their own. Referrals to specialists should therefore be made by a primary care provider in consultation with the patient.

Nevertheless, the Committee does not believe it appropriate to prohibit patients from consulting other doctors, especially specialists, should they so desire. But it does believe that patients who choose to seek care elsewhere, care that could be provided adequately within the PCG with which they are enrolled, should bear the financial consequences of their decisions. In other words, patients should be obliged to pay a fee in order to consult other physicians, including specialists, when they do so on their own initiative.

In order for primary care groups to function effectively, the Committee is convinced that they must act as gatekeepers to the rest of the health care system.

In Volume Five, the Committee also recommended the establishment of an ongoing framework to deal with human resource issues, in particular by creating a permanent national coordinating body for health human resources composed of representatives of key stakeholder groups and of the different levels of government. Its mandate would include coordinating initiatives to ensure that adequate numbers of graduates are being trained to meet the goal of Canadian self-sufficiency in health human resources.[144]

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[144] See also Chapter Eleven of this volume.

With respect to the development of electronic health records, the Committee recommended in Volume Five that the Canada Health Infoway initiative be extended beyond its current 3-5 year mandate in order to develop, in collaboration with the provinces and territories, a national system of electronic health records. Several witnesses suggested not only that the development of electronic health records is crucial to the reform of primary health care, but that it is an area in which the federal government can exercise leadership.

In the words of Jack Davis, CEO of the Calgary Health Region, "the one area I would see that has a real potential for federal investment is the electronic health record."[145] Dr. Kenneth Sky, past president of the Ontario Medical Association, suggested that "for physicians, the IT component of primary care reform is a big incentive,"[146] and Michael Decter felt that electronic health records were so important that "bribery is in order in this particular sphere. I would bribe the doctors to convert."[147]

The Committee agrees that the federal government should take the lead role in expediting the development of a national electronic health record, and presents specific recommendations to this effect in Chapter Ten.

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[145] 53:88

[146] 56:22

[147] 52:14

Appendix 4.1: GP Fundholding in Great Britain

In discussions of primary care reform, reference is often made to the British experience in the 1990s with the introduction of "internal markets". Before 1990, it was accurate to describe the British National Health Service (NHS) as being run by a monolithic bureaucracy that controlled all aspects of the system. At that time, NHS hospitals and community health care units were state-owned and operated by the NHS's regional health authorities. Each hospital's budget was determined through an administrative process involving negotiations between its management and the NHS administration. GPs provided care through a "rostering" system that required patients to register with one GP, who then acted as "gatekeeper" to the rest of the system. GPs worked under contract with the NHS and were remunerated through a mixed system that combined a salary with capitation based on the number of patients on a doctor's list.

With primary care reform, introducing internal markets allowed some general practices to volunteer as "Fundholders". Family practices that served a sufficient number of patients became purchasers who were then able to contract with hospitals and other community-based providers (such as cistrict nurses) for defined services. Fundholder budgets were restricted for the purchase of hospital and community services; they could not be used to supplement GPs incomes. GPs have always been paid by the NHS as independent, self-employed professionals. The various reforms enacted throughout the 1990s, such as fundholding and more recently the creation of Primary Care Groups and Trusts, have not fundamentally affected the ways in which British GPs derive their incomes.

In the early 1990s the GP fundholding system was expected to be only a small part of the overall reform process, but it quickly became more popular than anyone had anticipated, due to a variety of factors. There was evidence early on that fundholders could secure improved services for their patients. This created a bandwagon effect; few physicians wanted to be left behind. The Conservative government reinforced this trend by offering further benefits (e.g. computers) exclusively to fundholding practices. Moreover, fundholding gave GPs a central and more authoritative role in the overall system than they had had previously. Consultants (specialists) were forced to become more responsive and accountable to GPs who had the option to take their business (referrals) elsewhere.

The Labour government under Tony Blair, first elected in 1997, was critical of a number of aspects of internal market reform. In particular, it felt that GP fundholding had allowed a form of "two-tierism" to develop in Britain because patients of GP Fundholders were often able to obtain treatment more quickly than patients of non-Fundholders. This was considered inimical to the founding principles of the NHS, and as a result Labour sought to curb the forms of competition they saw as being at the root of emerging inequalities.

In April 1999, government required all GPs to join a Primary Care Group (PCG - groupings of GP practices in geographical areas far larger than the previous fundholding model, covering between 50,000 to 250,000 people.) PCGs brought local primary care providers together under a board dominated by GPs, but also representing nurses and other local community providers. PCGs were expected to develop through stages to become "Trusts" (PCTs) able to assume full responsibility for commissioning (contracting for) care and for the provision of community health services for their population. By April 2002, nearly all the PCGs had made the transition to Trust status.

In principle, this evolution gave all GPs the benefits of fundholding, a single regional budget encompassing general medical services, and prescription drugs, as well as hospital and specialist care. However, a recent assessment by the King's Fund suggests that there is still some way to go before PCTs "will be able to realise their undoubted potential." The authors of this study concluded that PCTs are developing at different speeds and that while "they have made progress in developing and integrating primary and community care…their commissioning and health improvement functions are, as yet, limited."[148]

It is worth noting that until the market reforms of the 1990s, GPs retained a monopoly on primary care delivery through their role as gatekeepers to all other dimensions of the system. A number of reforms introduced by the Labour government have allowed nurse-led providers to assume a growing role in this regard. These have included the creation of a nurse-staffed 24-hour telephone advice line (NHS Direct) and the creation of a number of walk-in centres where initial assessments are performed by nurses, who can then refer patients to local GPs if necessary.

A number of factors make it very difficult to draw definitive conclusions from the British experience that can be easily applied to the Canadian context. There have not always been sufficient data available, and the rapidity of change has not facilitated careful study. Moreover, given the very different structure of the two systems, it is difficult to apply the lessons to the Canadian health care system. However, a number of points bear mention:

- In the first place, despite the Labour Government's opposition to the form taken by the "internal market" under the previous Conservative government, the Labour governement has nonetheless retained key elements of the purchaser-provider split the Conservatives introduced.
- Second, the transition that the Blair government has engineered from GP fundholding to the creation of PCGs and PCTs would seem to highlight the successes of the fundholding scheme more than its deficiencies. It is because the fundholding GPs were successful in negotiating with hospital trusts on behalf of their patients that fears of "two-tierism" emerged.
- Third, the shift to grant a greater role in the delivery of primary health care services to nurses and other providers parallels similar recommendations that have been voiced consistently in the Canadian debate over primary care reform.

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[148] John Appleby and Anna Coote, *Five Year Health Check*, King's Fund, April 2002, p. 47.

TABLE 4 1
REVIEW OF RECENT PROVINCIAL REPORTS CONTAINING RECOMMENDATIONS ON PRIMARY HEALTH CARE REFORM

Report	Scope of service	Team Composition	Remuneration	Size of practice	EHR*	Rostering	External Relations
Sinclair (Ont.) Dec. 1999	Comprehensive primary care would be provided 24 hours a day, seven days a week; this would be achieved through after-hours clinics (or extended office hours) and around-the-clock telephone triage.	Physicians and nurse practitioners as "core providers", in an interdisciplinary team including: registered nurses, midwives, psychologists and social workers, pharmacists, physiotherapists, dieticians. Individual health care providers would work to the full extent of their scope of practice.	Group rather than individual funding, primarily on the basis of capitation supplemented by other methods; group determines how its member providers are reimbursed. Not merely office sharing.	Three distinct models: urban – 6 MDs, 2 NPs for about 1,680 patients; rural – 2 MDs and 2 NPs for 1,293 patients; remote – 1 MD and 3 NPs for 1,142 patients.	Yes	Yes	Each practice would be responsible for developing agreements with other health care organizations and providers (hospitals, specialists, public health, rehabilitation centres, long-term care facilities, home care, community care).
Clair (Que.) Jan. 2001	Group practices would ensure round-the-clock, seven-days-a-week coverage. Services to include health promotion and disease prevention, diagnosis and treatment, referral to hospitals and specialists, coordination of continuum of care, and referral to social care.	Practices comprise only physicians and nurse practitioners, but they work in partnership with the existing network of CLSCs (social workers, dieticians, psychologists, physiotherapists, etc.).	A blended system of remuneration that includes elements of capitation, a lump sum for participation in some programs, and FFS for prevention or to promote productivity.	6 to 10 physicians working in a polyclinic or within a CLSC with the collaboration of 2 to 3 nurse practitioners, and responsible for between 1,000 and 1,800 persons.	Yes	Yes	Contract with the regional health authority, and between the primary care group practice and the CLSC. Regional health authorities would be responsible for coordinating the network of primary care group practices with other service providers.
Fyke (Sask.) Apr. 2001	Group practices would make services available around the clock. Outside of office hours, telephone calls would be forwarded to a nearby group member; 24-hour back-up through a provincial call centre. No explicit list of services.	Primary care group practices would involve a variety of providers including physicians, nurse practitioners, midwives, physiotherapists, dieticians, home care workers, and professionals in the areas of mental health, rehabilitation, addiction and public health.			Yes		Regional health authorities would organize and manage primary care group practices, contracting with or otherwise employing all providers including physicians.

Report	Scope of service	Team Composition	Remuneration	Size of practice	EHR*	Rostering	External Relations
Mazan-kowski (Alta.) Dec. 2001	Gives very general approval to the idea of primary health care reform. Comprehensive care would be delivered by multidisciplinary teams.	Teams might include a family doctor, nurse or nurse practitioner, mental health worker, social worker and others.	Identifies FFS as a barrier to change. Suggests that a blended funding model is the best likely alternative, and sees the Ontario Family Health Network as an excellent example.		Yes		Physicians should be given the option of contracting with Regional Health Authorities for a portion of their income.
Nfld. Dec. 2001	A network of primary health care teams providing a 'Continuum of Care' (including preventative, promotive, curative, supportive and rehabilitative care).	Primary care physicians would work collaboratively with other health care providers and other physicians. Within each team, each health care provider would practice at the highest level of his or her respective skill set.	Did not endorse any specific funding method (no universal model) but seemed to support some form of flexible, blended funding. No mention of capitation.		Yes		Regional boards would outline for physicians what medical services are required for their region. Physician groups would enter into formal arrangements with boards to ensure delivery of the full basket of services listed in the agreement.
N.B. Jan. 2002	Access to a comprehensive range of ambulatory services 24-hours a day, seven-days a week, coordinated from one location, where possible a Community Health Centre. Where these would not be open 24 hours a day, phone calls would be re-directed to an around the clock service site.	A collaborative model and a team approach to providing primary care. Family physicians would not see every patient and other members from the team of health providers could provide consultation and/or perform treatment services. The goal would be to make full use of all providers based on their respective knowledge, skills and abilities.		All primary care services, where feasible, should be provided or coordinated through a network of Community Health Centres. These would be viewed as the physical 'nucleus' of primary care in the community.	Yes		Other providers could be accessed via telehealth and/or on site at the Community Health Centre.

*Electronic Health Record

Source: Library of Parliament

Part III: The Health Care Guarantee

CHAPTER FIVE

TIMELY ACCESS TO HEALTH CARE

Most of Volume Six covers specific issues relating to the delivery of health care. Hospital restructuring, financing health care, primary health care reform and expanding public coverage for prescription drugs, some home care and palliative care are all critical components of a fiscally sustainable health care system. This chapter, however, focuses on a less frequently discussed, but very important, issue – the right to health care and the implications of the *Canadian Charter of Rights and Freedoms* (the Charter) for the provision of *timely* access to medically necessary care.

Timely access to needed care does not necessarily mean immediate access. Nor is the issue of timely access limited to life-threatening situations. Timely access means that service is being provided consistent with clinical practice guidelines to ensure that a patient's health is not negatively affected while waiting for care.

The Committee feels it is important to stress that timely access to needed care does not necessarily mean immediate access. Nor is the issue of timely access limited to life-threatening situations. Timely access means that service is being provided consistent with clinical practice guidelines to ensure that a patient's health is not negatively affected while waiting for care.

The issue of timely access to health care is of particular importance at this time for the following reasons: First, repeated public opinion polls increasingly have shown that the greatest concern Canadians have about the existing publicly funded health care system is the perceived length of waiting times for diagnostic services, hospital care and access to specialists. This concern is evidence that timely access to health care – as that is defined by patients – is often not available.

Second, the lack of timely access to needed care can seriously contribute to the deterioration of a person's health and well-being. Given this fact, it is likely that increasing pressures will be exerted on governments, hospitals and physicians to ensure that medically necessary care is provided, within the publicly funded health care system, in a timely manner. It is also very likely that, failing substantial improvement, Canadians will exert pressure on government to make it legally possible for individuals to obtain timely care in a parallel private hospital and doctor system.

Third, if the pressure on government is not effective, for the reasons described below, the Committee believes that the courts are likely to rule unconstitutional current laws that effectively prevent Canadians from paying privately, in Canada, for health care services that are publicly insured.

Therefore, solving the timely access problem is critical if Canada is to preserve the single insurer model of the publicly funded hospital and doctor system that Canadians, and the Committee, so strongly support.

Do Canadians have a right to health care? Can Canadians be prevented from obtaining timely care when the publicly funded health care system fails to ensure timely access? This chapter addresses these questions.

5.1 The Right to Health Care – Public Perception or Legal Right?

To begin, it is important to distinguish between a legal right to health care and the public perception of the existence of that right. In Volume Four, the Committee noted the existence of public opinion polls that reveal that Canadians, encouraged by politicians and the media, believe they have a constitutional right to receive health care even though no such right is explicitly contained in the Charter.[149] Nor does any other Canadian law specifically confer that right, although government programs exist to provide publicly funded health services.[150]

The Committee has previously noted the existence of public opinion polls that reveal that Canadians believe they have a constitutional right to receive health care even though no such right is explicitly contained in the Charter.

The preamble to the *Canada Health Act*[151] (the Act) states that:

> *continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians.*

As well, section 3 of the Act provides that the primary objective of Canadian health care policy is:

> *to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.*

These statements from the *Canada Health Act*, supportive as they are, do not grant a right to health care.

Similarly, international instruments such as the *Universal Declaration of Human Rights, 1948*, to which Canada is a signatory, speak of the right to a standard of living adequate for health and well-being, including medical care and the right to security in the event of sickness and disability; but they too do not provide a basis for a constitutional, or even legal, right to health care.[152]

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[149] Volume Four, p. 38.

[150] Colleen Flood and Tracy Epps, *Can a Patients' Bill of Rights Address Concerns About Waiting Lists?* Draft Working Paper, Health Law Group, Faculty of Law, University of Toronto, October 9, 2001, p. 7.

[151] R.S. 1985, c. C-6.

[152] The Canadian Bar Association Task Force on Health Care, *What's Law Got To Do With It? Health Care Reform in Canada*, (Ottawa: The Canadian Bar Association, August 1994) p. 24.

Clearly, there is a significant discrepancy between what the public believes and the absence of a legal right to health care.

Despite the absence of a legislated right to health care, there is a growing body of literature and court decisions on the effect of the *Canadian Charter of Rights and Freedoms* in the context of health care. Of particular interest are the implications of section 7 of the Charter for the provision of timely health care in Canada.

5.2 The Extent to which Publicly Insured Health Services are Available Outside the Publicly Funded Health Care System

In Volume Four, the Committee discussed the impact of the *Canada Health Act* on the provision of privately funded health care. We stressed that the Act does not prohibit the provision of privately paid-for health services. Rather, the Act sets out the conditions under which the provinces and territories will receive or be denied full federal funding for providing medically necessary physician and hospital services to their residents.[153]

In order to receive full federal funding, provincial and territorial public health care insurance plans must meet the five key conditions: public administration, comprehensiveness, portability, universality and accessibility. The *Canada Health Act* also creates an important incentive for the provinces and territories to discourage doctors and hospitals from extra-billing patients or imposing user charges for medically necessary health services. If extra-billing occurs or user charges are required, the federal cash contribution provided under the CHST can be reduced by an equivalent amount.

The *Canada Health Act* does not contain prohibit health care providers who do not bill their provincial health care insurance plans from delivering, and being compensated privately for, provincially insured health services. Moreover, the Act does not limit, in any way, the delivery of publicly insured services by privately owned (not-for-profit or for-profit) service delivery institutions. Indeed, private health care institutions currently deliver publicly insured health services in every province. What the *Canada Health Act* does is provide for significant financial penalties when provinces allow private payments for publicly insured services, particularly where extra-billing and user charges are involved.

Provincial and territorial legislation work in tandem with the *Canada Health Act* to discourage and/or prevent medically necessary services from being provided outside the publicly funded health care system. Physicians can opt out of providing services in the public health care system and bill patients directly, but a variety of provincial regulations effectively discourage physicians from doing so. Many provinces prohibit opted-out doctors from charging patients more than the public system rate. Some provinces deny reimbursement to patients who receive insured health services from opted-out doctors. Moreover, the majority of provinces do not permit private health care insurance to be purchased for services insured under provincial health care plans, even though all of them allow residents to purchase private insurance for hospital and physician services that are not classified as "medically necessary."[154]

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[153] Volume Four, pp. 38-39.

In Volume Four, the Committee said:

> *The Canada Health Act along with provincial/territorial legislation has prevented the emergence of a private health care system that would compete directly with the publicly funded one. It is simply not economically feasible for patients, physicians or health care institutions to be part of a parallel system.*[155]

The end result is that Canadians have few, if any, real options in this country when the publicly funded health care system fails to provide timely care. Those who can afford to do so may seek care in the United States, but most simply wait hoping, sometimes in vain, that the public system can accommodate them.

The Committee is concerned that Canadians have few, if any, real options in this country when the publicly funded health care system fails to provide timely care. Those who can afford to do so may seek care in the United States, but most simply wait hoping, sometimes in vain, that the public system can accommodate them.

5.3 Timely Health Care and Section 7 of the Canadian Charter of Rights and Freedoms

The presence of long waiting lists for certain medically necessary treatments and hence the absence of timely care raise a number of issues, not the least of which relate to the rights and entitlements of patients who are waiting for care. In this regard, in its Volume Four, the Committee posed the following questions:

> *If a right to health care is recognized under section 7 of the Charter, and if access to publicly funded health services is not timely, can governments continue to discourage the provision of private health care through the prohibition of private insurance?*
>
> *Is it just and reasonable in a free and democratic society that government ration the supply of publicly funded health services (through budgetary allocations to health care) and simultaneously, effectively prevent individuals from obtaining the service in Canada, even at their own expense?*[156]

These questions have provoked considerable debate that, in the Committee's view, has significant implications for the Canadian health care system, as we know it. Indeed, the Committee raised these questions both to stimulate discussion and to caution governments that policies and laws that restrict, or discourage, access to privately funded health care will be increasingly difficult, if not impossible, to maintain if timely access to medically necessary care is not provided in the publicly funded system.

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[154] Colleen M. Flood, Tom Archibald, "The illegality of private health care in Canada", *Canadian Medical Association Journal*, March 20, 2001, 164 (6), p. 825-830.

[155] Volume Four, p. 40.

[156] *Ibid.*

Thus, in the Committee's opinion, the failure to deliver timely health services in the publicly funded system, as evidenced by long waiting lists for services, is likely to lay the foundation for a successful Charter challenge to laws that prevent or impede Canadians from personally paying for medically necessary services in Canada, even if these services are included in the set of publicly insured health services.

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The *Canadian Charter of Rights and Freedoms* guarantees certain fundamental rights and freedoms. Section 7 of the Charter states:

> *Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.*

Although the Charter makes no explicit references to health care, it has been argued that section 7 has significant implications in the health care question. The section 7 argument is not based on a constitutional guarantee to government-funded health care, but rather on the section 7 rights to liberty and security of the person which, it could be argued, may be impaired if adequate and timely health care cannot be provided in the publicly funded health care system.

These rights, then, could be interpreted to imply that if individuals are unable to get timely care within the publicly funded health care system, governments should not be able to prevent an individual from paying for the service in order to obtain the service elsewhere in Canada. That is, while health care itself may not be a right, individuals do have the right not to be prevented by government from seeking timely health care elsewhere in Canada, if the service cannot be provided in a timely manner within the publicly funded system.

In 1994, the Canadian Bar Association Task Force on Health Care expressed the opinion that there is no right to health care under the Charter. This conclusion was based on the view that the Charter is often interpreted as a negative rather than a positive instrument – one that generally does not compel governments to act in a particular manner, but rather protects Canadians against coercive government action.[157]

In the context of health care, then, the Charter might not require governments to ensure that a certain level of health care is available in the publicly funded system, but the

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[157] ***What's Law Got To Do With It? Health Care Reform in Canada*, (1994) p. 26.**

Charter could be employed to stop governments from taking restrictive measures that deny individuals from having the freedom to seek health care on their own in Canada when the publicly funded system fails to provide such care in a timely manner.

Indeed, the Task Force pointed out that individuals could advance the legal argument that section 7 includes a right to purchase health services when government cannot ensure, or is not willing to ensure, the provision of adequate services (which could clearly include a government not providing the service in a timely manner).[158]

Legal experts told the Committee that section 7 has application to health care and it is just a matter of time before its parameters are explored more thoroughly in the courts. Recent judicial decisions give evidence of a probable expansion of the Charter in relation to health care. Cases based on section 15 of the Charter, the equality section, have had some success.[159] But the implications of section 7 for timely access to health services have yet to be fully tested in the courts.

In a recent C.D. Howe Institute Commentary, entitled *The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians,*[160] authors Stanley Hartt and Patrick Monahan examine whether governments can prohibit or impede Canadians from accessing medically necessary health services by paying for them privately, if timely access to such services is not available in the publicly funded health care system.

Basing their analysis on section 7[161] of the Charter, Hartt and Monahan conclude that, when the publicly funded health care system fails to provide timely access to medically necessary care, restrictions on private payment or the purchase of private health care insurance violate an individual's right to liberty and security of the person guaranteed by section 7 and are inconsistent with the principles of fundamental justice. Because this Commentary is probably the most detailed examination of the application of section 7 in the health care context to date, the Committee believes it is worth outlining Hartt and Monahan's arguments in some detail.

Hartt and Monahan maintain that an individual's decisions with respect to his or her medical care are fundamental personal decisions affecting health, life and death and are therefore protected under the section 7 liberty guarantee. Consequently, when governments effectively prevent individuals from obtaining health care outside the publicly funded system, they have a concomitant obligation to ensure that timely care is provided within that system.

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[158] *Ibid.*, p. 94.

[159] In *Eldridge v. British Columbia (Attorney General)* [1997] 3 SCR 624, the Supreme Court of Canada held that the provincial government's failure to fund sign-language interpreters in hospitals under its public health insurance system discriminated against deaf patients on the basis of physical disability and violated their equality rights under section 15 of the Charter.

[160] Stanley H. Hartt Q.C., Patrick J. Monahan, *The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians*, C.D. Howe Institute, Commentary, No. 164, May 2002.

[161] According to Hartt and Monahan (p. 9), a claim under section 7 of the Charter has three aspects:
1) An action of a legislature or government that deprives a person of one of more of "life, liberty and security of the person"; 2) The deprivation must be contrary to the principles of fundamental justice; 3) The violation cannot be justified under section 1 of the Charter, which requires that a violation of a protected right must be a "reasonable limit" that can be demonstrably justified in a free and democratic society.

Hence, when the public system cannot or will not deliver timely care, Hartt and Monahan argue that individuals should be free to acquire the necessary care elsewhere. And hence, under these circumstances, restrictions on the ability to access care outside the public system, including restrictions on the right to buy private health care insurance, constitute a violation of the right to make personal decisions affecting life and health as provided under section 7's liberty guarantee.[162]

The right to security of the person under section 7 has both a physical and a psychological aspect which, on the basis of the 1988 Supreme Court of Canada decision in the *Morgentaler* case, Hartt and Monahan interpret as encompassing the adverse physical and psychological impacts associated with excessive waiting for medical care. They assert:

> ***Where governments institute measures that delay or impede access to medically necessary services and where that delay materially increases medical risks or otherwise results in adverse health consequences, the violation of security of the person is clear.***[163]

Even if there is a limitation on the right to liberty or security of the person, however, section 7 will not be violated unless it can be shown that the limitation is inconsistent with the "principles of fundamental justice." While the courts have concluded that fundamental justice has both procedural and substantive aspects, the term has not been specifically defined. Hartt and Monahan argue that it is manifestly unfair, and therefore contrary to the principles of fundamental justice, to establish a system where medically necessary services are for all intents and purposes accessible only through the public health care regime but are unavailable on a timely basis.[164]

Consequently, Hartt and Monahan maintain that, if health services are not available on a timely basis, then provincial governments cannot legally prohibit Canadians from obtaining those services in Canada, nor can the federal government use the financial penalties in the *Canada Health Act* to compel the provinces to enforce constitutionally invalid restrictions.[165] In other words, governments cannot fail to ensure the provision of timely access to medically necessary health services and at the same time prevent Canadians from obtaining such services outside the publicly funded system. This includes governments being unable to prevent Canadians from acquiring private health care insurance to cover the cost of purchasing such services outside the publicly funded system.

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[162] *Ibid.*, p. 17.

[163] *Ibid.*, p. 15.

[164] *Ibid.*, p. 20-21.

[165] *Ibid.*, p. 5.

It would follow, if Hartt and Monahan are correct, that the Charter would prevent the prohibition by government of an individual's right to obtain health services privately when the government fails to provide such services in a timely manner:

> *Existing restrictions on the private purchase of medically necessary services are entirely justifiable in circumstances where such medical services are available on a timely basis through the public system.*[166]
>
> *(...) where the publicly funded health care system fails to deliver timely access to medically necessary care, governments act unlawfully in prohibiting Canadians from using their own resources to purchase those services privately in their own country. In these circumstances, the restrictions on private payment and private health insurance that are found in the laws of various provinces force Canadians into a system that, at a minimum compromises their health and potentially may endanger their lives.*[167]

However, Hartt and Monahan's analysis does not conclude that the only remedy is for government to relax the restrictions on an individual's ability to purchase private health care insurance. Indeed, Hartt and Monahan believe governments can do one of two things – governments can either finance and structure the publicly funded health care system in such a way that it provides timely access to medically necessary care, or they can allow Canadians to buy that care if such access is not available in the publicly funded health care system in a timely manner.[168]

The Committee finds the Hartt and Monahan analysis compelling. However, at the same time, it should be noted that the Quebec Superior Court reached a different conclusion in a case [*Chaoulli* c. *Québec (Procureure générale)*][169] where section 7 of the Charter was used to dispute the Quebec government's prohibition on the purchase of private health care insurance to pay for the private provision of health services which are also covered under the provincial health care insurance plan. *Chaoulli* dealt with the plaintiff's wish to buy private insurance for future care and treatment to which timely access *might* be denied. In other words, the *Chaoulli* case dealt with potential future events that *might* possibly take place, and not with events that had already occurred. Thus, the *Chaoulli* case is not directly on the issue discussed in the Hart and Monahan paper because it is dealing with a speculative future event.

Governments can do one of two things – governments can either finance and structure the publicly funded health care system to provide timely access to medically necessary care, or they can allow Canadians to buy that care if such access is not available in the publicly funded health care system in a timely manner.

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[166] *Ibid.*, p. 3.
[167] *Ibid.*, p. 4.
[168] *Ibid.*
[169] [2000] J. Q. No. 470 (QL) (C.S.Q. Piche J.)

The Quebec Superior Court refused the Chaoulli claim, concluding that, although prohibitions on private insurance could violate rights of liberty and security of the person under section 7 of the Charter, it was nevertheless consistent with the principles of fundamental justice under section 7 to deny the ability to purchase private insurance for medical services covered under the Quebec public health care insurance plan.[170]

In determining whether the Quebec restrictions were consistent with the "principles of fundamental justice" and therefore not a violation of section 7, the Court sought to balance the right to purchase private health care insurance against the collective goal of ensuring equal access to medically necessary health services for all Quebec residents. To allow private health care insurance, in the court's view, would compromise the integrity, proper functioning and viability of the publicly funded health care system.[171] In reflecting on this court decision, it is important to keep in mind that this was a decision by a court of first instance and has yet to be commented on by an appellate court or by the Supreme Court of Canada.

It is also worth noting that this conclusion was reached in spite of the fact that in European countries and Australia, which have universal and publicly funded health care systems, the purchase of private health care insurance is permitted and does not appear to have caused irreparable damage to the functioning and viability of their publicly funded health care systems.

It must also be pointed out that experience in these countries severely weakens the argument which some have made that even if the prohibition on purchasing health care insurance violates an individual's right to timely health care, this violation can be justified under section 1 of the Charter. In order for this argument to be valid, the violation must be a "reasonable limit" that can be "demonstrably justified in a free and democratic society." Since other free and democratic societies have universal health care systems and also allow individuals to purchase health care insurance which can be used to cover the cost of obtaining such services outside the publicly funded system, and since the health care systems in these countries appear to function effectively, the courts may be unwilling to accept the argument that the violation of an individual's right to timely health care (by prohibiting a parallel private system) is a "reasonable limit that can be demonstrably justified."

Although not argued on Charter grounds, another Quebec case (*Stein* v. *Quebec (Régie de l'Assurance-maladie)* took a different approach by holding the provincial government responsible for reimbursing a patient's medical expenses incurred in the United States for treatment for a life-threatening condition when timely access to the required care was not available in Quebec.[172] In the Stein case, the patient was advised to seek surgery for life-threatening cancer no later than four to eight weeks after the diagnosis. After waiting longer than the suggested period for the required treatment, Stein sought medical care in New York. Subsequently, Stein contested the Quebec health care insurance board's refusal to reimburse his medical expenses. The court sided with Stein, noting that in his circumstances, where the danger to his life was increasing daily, it was unreasonable for him to have to wait for surgery in Montreal. In this case, it is worth noting the emphasis the court placed on timely access to care.

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[170] *Ibid.*, para. 243.

[171] *Ibid.*, para. 261-263.

[172] *Stein* v. *Québec (Régie de l'Assurance-maladie)*, [1999] QJ No. 2724.

5.4 Committee Commentary

Even though Canadian courts have not yet established a right to health care under the Charter, it is clear to the Committee that, when timely access to appropriate care is not available in the publicly funded health care system, the prohibition of private payment for health services becomes increasingly difficult, if not impossible, to justify. The rights to liberty and to security of the person under section 7 of the Charter are likely to be violated when timely access to publicly funded health care is denied and, simultaneously, Canadians are effectively prevented from obtaining the required care elsewhere in Canada.

The failure to address effectively the issue of the lack of access to timely care is also highly likely to lead to the establishment of a parallel private hospital and doctor system.

The failure to address effectively the issue of the lack of access to timely care is also highly likely to lead to the establishment of a parallel private hospital and doctor system. Therefore, solving the waiting time issue, or lack of timely care problem, is critical if Canada is to preserve the single payer model of health care that Canadians, and the Committee, so strongly support.

It is the Committee's strong belief that governments should not be passive and wait for the courts to determine how Canadians will gain timely access to medically necessary care. The time has come when governments *must* address the waiting time problem.

Governments cannot continue to turn a blind eye to the increasing problem of the lack of timely access to health care. They, and the providers of care themselves – particularly hospitals and physicians *must* find a solution to the problem of providing timely access to appropriate levels of health care.

The Committee's preferred approach to solve the problem of long waiting times, and thus avoid the development of a parallel private system, is twofold: first, more money must be invested in health care for the purposes described in the other chapters of this report; and second, governments must establish a national health care guarantee – a set of nationwide standards for timely access to key health services – the parameters of which we explore in the next chapter.

It is the Committee's strong belief that governments should not be passive and wait for the courts to determine how Canadians will gain timely access to medically necessary care. The time has come when governments must address the waiting time problem.

CHAPTER SIX

THE HEALTH CARE GUARANTEE

6.1 The Public Perception of the Problem of Waiting Lists

The accessibility principle of the *Canada Health Act* stipulates that Canadians should have "reasonable access" to insured health services. However, the Act does not define what constitutes reasonable access. Lately, concerns about access to health care have been associated with the problem of waiting lists and times – that is, lack of timely access is increasingly perceived to be a major problem plaguing the health care system. Of course, "timely" is a subjective word; what is timely to one person may be an eternity for another, particularly where illness is involved. Nevertheless, the Committee believes that "timely access" describes more accurately what the public expects from the publicly funded health care system than "reasonable access."

Results of a study conducted by Statistics Canada released in July 2002[173] provide, for the first time, a reliable indication of the extent to which Canadians perceive lengthening waiting times to be a major failing of the publicly funded health care system. The survey revealed that "almost one in five Canadians who accessed health care for themselves or a family member in 2001 encountered some form of difficulty, ranging from problems getting an appointment to lengthy waiting times."[174] And, of the estimated 5 million people who visited a specialist, roughly 18%, or 900,000 people, reported that waiting for care affected their lives. The majority of these people (59%) reported worry, anxiety or stress. About 37% said they experienced pain. The report concluded that:

The Committee learned that almost one in five Canadians who accessed health care for themselves or a family member in 2001 encountered some form of difficulty, ranging from problems getting an appointment to lengthy waiting times.

> *Perhaps the most significant information regarding access to care was about waiting times. According to the results of the survey, Canadians reported that waiting for services care was clearly a barrier to care… Long waits were clearly not acceptable to Canadians, particularly when they experienced adverse affects such as worry and anxiety or pain while waiting for care.*[175]

These new Statistics Canada data suggest strongly that the anecdotal evidence concerning the growing problem of waiting lists cited by the Committee previously corresponds to a real and growing problem confronting the publicly funded health care system in Canada.

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[173] *Access to Health Care Services in Canada, 2001*, Claudia Sanmartin, Christian Houle, Jean-Marie Berthelot, and Kathleen White, Statistics Canada, June 2002.

[174] Statistics Canada, *The Daily*, July 15, 2002.

[175] *Access to Health Care*, p. 21.

The Committee is firmly convinced that this problem must be addressed. The status quo is simply unacceptable. Before presenting the Committee's recommendations, this chapter examines Canadian and international experience in dealing with the problem of waiting times.

6.2 The Reality of the Waiting List Problem

One of the aspects of the waiting list issue that the Committee has found most troubling is the lack of accurate data on the numbers of Canadians who must wait to consult specialists, obtain diagnostic procedures or receive treatment in a hospital, and the absence of accurate data on the length of time they are having to wait and for what services relating to what diseases, conditions and indications. This lack of data poses a serious dilemma for public policy makers. There is strong public perception of a serious waiting list problem, but few or no data by which to measure the extent of that problem, and few standards and protocols to assign needs-based priority to those waiting for treatment.

One of the aspects of the waiting list issue that the Committee has found most troubling is the lack of accurate data on the numbers of Canadians who must wait to consult specialists, obtain diagnostic procedures or receive treatment in a hospital, and the absence of accurate data on the length of time they are having to wait and for what services relating to what diseases, conditions and indications.

On the one hand, whether a social problem is real or only perceived, governments naturally want to be seen to be responding to it. On the other hand, with regard to the waiting list problem, if, from the perspective of genuine clinical need (as opposed to patient demand), the health of patients is not being compromised while waiting for diagnosis or treatment, there is little justification for spending a lot of money increasing the supply of the health care resources in question. Determining the true extent of waiting list problems, and their impact on the health and well-being of the people affected, is fundamental to formulating an appropriate public policy response.

What is known is that there are two excellent examples of objectively prioritized waiting lists in Canada – the Cardiac Care Network of Ontario and the Western Canada Waiting List Project. These show that, with the creation of disciplined waiting lists in which patients receive treatment according to their priority of need and within a timeframe set by clinical guidelines, the problem of waiting and the perception that the times are too long can be alleviated and in many cases resolved.

These examples also show that the use of needs-based clinical guidelines for waiting list management makes clear the real need for new resources; i.e., when patients with prioritized need cannot be provided with timely access by waiting list management alone and hence when new resources are needed. Moreover, if new resources are required, whether the resources be money, equipment, health care providers or hospital beds, a needs-based approach to managing waiting lists shows clearly what type, and how much, of the various new resources are required.

From a policy standpoint, therefore, it is essential that Canada begin to develop, as quickly as possible, an accurate database on waiting lists together with needs-based service criteria for people waiting for care, like the criteria described in the next section. Indeed, one of the reasons for the Committee's emphasis on the need for a dramatic and accelerated improvement in health information systems (see Chapter Ten) is precisely to enable the development of prioritized waiting lists and data on their application.

However, the Committee believes that Canadians should not have to wait until completion of this essential step to address a problem that should have been tackled years ago. Patients and their families must see clear evidence, first, of governments' determination to act and second, of progress on the waiting list problem. Therefore, in section 6.5 below, the Committee recommends that a "health care guarantee," that is, a set of needs-based maximum waiting times, be put in place *immediately*.

6.3 Canadian Experience

As stated above, two Canadian examples provide strong evidence that it is possible to tackle the problem of waiting lists.

6.3.1 Cardiac Care Network of Ontario

The Cardiac Care Network of Ontario (CCN) has long been recognized as a model for managing waiting times, primarily by creating a needs-based priority order of waiting. Established in 1990 to coordinate, facilitate and monitor access to advanced cardiac care as well as to advise the ministry on adult cardiac care issues, CCN has since developed processes to facilitate and monitor patient access, a broad range of guidelines for cardiac services and a comprehensive provincial cardiac information system to support the provision of care, research and continuous improvement in services. Initially focused on cardiac surgery, CCN's priorities have been broadened to include catheterization, angioplasty and stents, as well as pacemakers, implantable cardiac defibrillators and cardiac rehabilitation.

CCN uses information about patients and their medical condition to calculate an urgency rating score (URS). The URS is a guideline to aid in prioritizing patients' need for care, i.e., a disciplined waiting list based on relative need for the services concerned. It is also used in monitoring the timely availability of care throughout the province. Regardless of the service needed, the more serious a patient's condition (as determined by the patient's URS), the sooner he or she receives care. As a result of CCN's efforts, waiting times for bypass surgery have dropped substantially since the mid-1990s. Median waiting times for patients whose need is considered to be urgent have consistently remained at about three days, regardless of variation in the total number of patients on the list.[176]

6.3.2 The Western Canada Waiting List Project

The results of the Western Canada Waiting List (WCWL) project, published in March 2001,[177] indicate that it may be possible to generalize the kind of system employed by the

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[176] See the submission of the Cardiac Care Network to the Commission on the Future of Health Care in Canada, October 29, 2001.

[177] *From Chaos to Order: Making Sense of Waiting Lists in Canada*, Final Report, the Western Canada Waiting List Project, March 2001.

CCN and apply it to other major illnesses and procedures. The WCWL project is a collaborative undertaking by a variety of organizations, including regional health authorities, provincial medical associations, provincial ministries of health, and health research centres. It was established to address the perception of significant and long-standing problems of access to health care in Western Canada and to influence the way in which waiting lists are structured, managed, and perceived.

In Canada, patient prioritization is not standardized for any medical service (with the exception of CCN in Ontario). This means that there is currently no provincially or nationally accepted method of measuring or defining waiting times for medical services, nor are there standards and criteria for "acceptable" waits for the vast majority of health services. It is impossible, therefore, to determine whether, from a clinical point of view, patients have waited a reasonable or unreasonable length of time to access care. The absence of standardized criteria and methods to prioritize patients waiting for care means that patients are placed and prioritized on waiting lists based on a range of clinical and non-clinical criteria that vary by individual referring physician across institutions, regional health authorities, and provinces.

Production of physician-scored point-count tools for assigning priority to patients on waiting lists was the overarching goal of the WCWL project. This task was carried out in five significantly different clinical areas: cataract surgery; general surgery procedures; hip and knee replacement; MRI scanning; and children's mental health. A set of priority criteria and a scoring system were developed through extensive clinical input from panel members. These went through several stages of empirical work assessing their validity and reliability. Clinicians who tested the priority setting tools generally concluded that they had the potential to be useful in clinical settings.

The results from the WCWL project indicate that clinicians, administrators, and the public believe that better management of waiting lists is necessary, possible and appropriate. What is necessary now is to develop appropriate standards and criteria to work out acceptable waiting times for patients at different levels of priority of need. The WCWL was not able to undertake this work, given that it was not part of the mandate associated with its funding.

Nonetheless, the authors of the WCWL final report contended that there is a strong possibility of achieving some semblance of order in establishing treatment priorities and access to elective care. Experience from other jurisdictions has shown that systematic approaches and priority setting techniques can be used to improve the management of waiting times. Research conducted for the WCWL project[178] suggested a number of approaches to make this happen, including the following:

- the process to establish standard definitions for waiting times should be national in scope
- standard definitions should focus on four key waiting periods – waiting for primary care consultation; for initial specialist consultation; for diagnostic tests; and for surgery.

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[178] Sanmartin, Claudia, "Toward Standard Definitions of Waiting Times for Health Care Services," p.361.

As CCN and the WCWL clearly show, substantial improvement in both the reality and perception of the waiting list problem is possible through adopting an approach based on the clinical needs of patients on waiting lists. Since few or no data are yet available to establish how much the problem can be improved with new waiting list management techniques, there are those who suggest that it would be jumping the gun to act before the real, as opposed to the perceived, extent of the waiting list problem is fully understood. They believe that implementing measures such as the Committee's proposed health care guarantee (described in section 6.5, below) would be premature. The Committee rejects this point of view. In the Committee's view, Canadians deserve a health care guarantee ***now***. At the least, such a guarantee would serve as a spur to the creation of the necessary standards, criteria and information systems. Certainly, a health care guarantee would alleviate much of the current anxiety of patients and their families.

***In the Committee's view, Canadians deserve a health care guarantee* now.**

6.4 International Experience

While there are no definitive conclusions to be drawn from international experience, there is evidence that establishing formal maximum waiting times for specific procedures can have a positive influence on reducing actual waiting times. Several factors limit the lessons that can be drawn from international examples. In the first place, health care systems are extremely complex and are rooted in the particular history and culture of the country in which they operate. With respect to the specification of maximum waiting times – or what the committee has called the health care guarantee – experience is limited to a small number of countries, is very recent, and recommended maximum waiting times have been subject to revision. Despite these caveats, the Committee believes it is possible to draw on international experience to improve the situation relating to waiting times in Canada.

6.4.1 Sweden

In its previous reports,[179] the Committee referred to the Swedish experience in the early 1990s with a form of health care guarantee. This guarantee established a maximum waiting time for diagnostic tests (90 days), certain types of elective surgery (90 days), and consultations with primary care doctors (8 days) and specialists (90 days). Sweden also put in place a system where waiting times for major procedures are posted daily on a website. People can check the website and may choose to travel to the hospital and next available physician or surgeon with the shortest waiting time.

In 1997, a revised health care guarantee came into force – the so-called "0/7/90" guarantee. It stipulates that patients must receive care from a nurse practitioner in a primary health care centre the same day and that an appointment with a physician must be offered within seven days. Finally, should a patient need referral to a specialist, an appointment must be offered with three months. When appointments cannot be offered within these time limits, the patient is entitled to see a health care provider in another county at no additional cost. When treatment is required, the health care guarantee states that it must be provided without delay but no maximum waiting times are specified.

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[179] See, for example, Vol. 5, p. 56 and Vol. 3, p. 33.

Overall, the care guarantee in Sweden appears to do more to improve patients' freedom of choice than constitute a mechanism to regulate waiting times. Under the Stockholm County Council, for example, patients can choose among many providers and institutions but in practice relatively few patients exercise this freedom of choice, and not all even know of its availability. For the most part, Swedes place high value on proximity to care; it seems that the vast majority of patients prefer to receive care in their own county rather than travel elsewhere, even if it means waiting longer.

6.4.2 Denmark[180]

In Denmark, the Ministry of Health and the Association of County Councils, who are jointly responsible for funding and delivering health care services, agreed in 1993 on a target, to be reached by the end of 1995, of a three-month maximum waiting time for all non-acute surgical treatment. The guarantee was accompanied by financial incentives for the counties to meet this target. But, in spite of increased activity and generally decreasing waiting times, it proved impossible for the counties to fulfill the guarantee and it was subsequently revoked in 1997.

Until very recently, a "political" approach was used to encourage reduction in waiting times by providing associated increases in health care funding. Differentiated targets were developed based on assessments of the impact of waiting times on different patient groups. As of March 2000, targets had been set for life-threatening heart conditions (two, three or five weeks depending on the specific diagnosis and treatment available), breast cancer, lung cancer, uterine cancer and intestinal cancer (two weeks from referral to preliminary investigation, two weeks from patient acceptance of surgery to surgical intervention, and two weeks from surgery to the start of post-surgical treatment).

A central government report published in 2000 indicated that the overall percentage of patients waiting more than three months fell from 32% in 1995 to 28% in 1997 and 21% in 1998. In 1998, 71% of all patients were treated immediately, 14% were treated within a month and 8% had to wait more than three months. The average waiting time for surgical procedures declined from 93 days in 1995 to 87 days in 1997.

Since 1997, the Ministry of Health has posted on the Internet expected waiting times at different hospitals for 24 types of diagnoses. This initiative was intended to broaden patients' ability to choose among hospitals throughout the country. In June 2001, the Social Democratic government announced an investment of 500 million kroner (about $100 million CAD) to reduce further waiting times for cancer treatment, and followed that with legislation to expand guaranteed minimum waiting times to patients with all forms of cancer.

Nonetheless, in the Danish elections in November 2001, concern over growing waiting times at public hospitals was one of the factors that contributed to the defeat of the

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[180] For a detailed description of the Danish health care system, see *Health Care Systems in Transition: Denmark*, Signild Vallgarda Allan Krasnik and Karsten Vrangbaek, the European Observatory on Health Care Systems, 2001.

Social Democrats at the hands of the right-wing Liberal Party. The new government has since allocated a further 1.5 billion kroner (about $290 million CAD) to be distributed throughout the publicly funded hospital system solely for the purpose of reducing waiting lists.

The government has also declared that, as of July 1, 2002, patients forced by the public system to wait longer than two months for treatment of any kind have the right to choose a private hospital or a hospital in another country without paying additional fees. As in Sweden, the Danes see this as an extension of patient choice, rather than a true health care guarantee. Mr. John Erik Petersen, Head of Department, Ministry of Health and the Interior, Government of Denmark, who testified before the Committee via videoconference, explained it as follows:

> *We introduced a free choice of hospitals among the public hospitals 10 years ago. However, we have not yet had free choice for the few Danish private hospitals, nor hospitals abroad.*
>
> *As of July 1, we are introducing an extended free choice of hospital to include private hospitals and hospitals in other countries in cases where the patient cannot be treated in the public hospitals in his own country or neighbouring counties within two months. That is where the care guarantee comes in. It is not really a guarantee, but it is an extended free choice after two months of waiting time.*
>
> *We also have a care guarantee, but that is only in a few areas of life-threatening cancer and heart diseases. That has been in effect for a year now. That is a guarantee in the sense that the councils, the hospitals, are obliged to find care opportunities for the patient within the time limits, which are shorter than two months. They are obliged to find care for the patient, which is not the case with the extended free choice. You get a free choice to private hospitals or abroad if you wait more than two months, but there is no guarantee that there is a private hospital that will take care of you.*[181]

Interestingly, as in Sweden, the Danes do not expect many people to take advantage of the new guarantees. Mr. Petersen further explained:

> *With regard to the two-month time limit, we do not foresee that all waiting times over two months will disappear in Denmark. We know already from the existing free choice among public hospitals that patients often choose to wait longer to be treated at their local hospitals rather than travelling to Europe and other parts of the country, even though Denmark is a rather small country. Therefore, we do not foresee that that many people will take advantage of this offer.*[182]

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[181] Committee Proceedings, June 17, 2002. 64:4.

[182] *Ibid.*, 64:

The Danish witnesses suggested to the Committee that the determination of two months as the period after which Danes could exercise free choice of hospital had more to do with political dynamics than with evidence-based clinical decision-making. This contrasts with the maximum waiting times for cancer and heart diseases that were established on the basis of clinical criteria. Nonetheless, the two-month guarantee represented, in the words of Dr. Steen Friberg Nielsen, CEO, Top Management Academy, Government of Denmark, "a political decision regarding the level of service"[183] that the government was committed to offer its citizens.

6.5 Committee Recommendations

The Committee believes that there are two sets of factors that contribute to the perceived growing problem of waiting times in Canada.

One is the apparent shortage of personnel and diagnostic equipment. In the Committee's view, these shortages have been severely exacerbated by decisions taken by governments at all levels over the past decade – decisions made as governments sought to reduce health care costs (and other public expenditures) dramatically. This has led to a situation in which some components of the health care system are increasingly unable to respond to the demands that are placed upon them. In a system that strives to treat everyone equally, this imbalance between the supply of services and the demand for them has resulted in growing waiting times, and, as the Statistics Canada data show, growing public concern over their length.

But the lack of disciplined, prioritized waiting lists based on standards, criteria and clinical, need-based data on the condition of patients substantially exacerbates this problem. The absence of data certainly makes it harder to determine what to do about it. In fact, in Canada's health care system it is impossible to distinguish effectively between genuine, clinically based patient needs on the one hand, and, on the other, patient- and physician-generated demand for immediate service (when waiting would have no impact on the person's health).

Not all waiting lists are the result of shortages. As already noted, evidence suggests it is possible to reduce these waiting times by tackling them head-on, as CCN has done in Ontario. We strongly suggest that a major factor contributing to growing waiting times has been the slowness of the "players" in the system – hospitals and their specialist physicians and surgeons in particular – to apply systematic management to waiting lists for all major procedures, diagnostic tests and consultations. In the same spirit in which it supports all efforts to improve the efficiency of the health care system, the Committee welcomes attempts to find better ways to manage waiting lists, such as the WCWL project, so that patients in the greatest need are tended to first and that, wherever possible, waiting times for everybody are kept to a minimum. The Committee believes, however, that it is highly unlikely that better management of waiting lists will, on its own, suffice to resolve the waiting list problem. Undoubtedly some of it is attributable to shortages.

The question then arises why the situation has been allowed to deteriorate to the point where almost one in five Canadians reports difficulty in accessing needed health services in a timely manner. In the Committee's view, one reason is that cost-cutting – or, more precisely, the failure to continue to increase funding at the same rate as growth in health care costs – has been an option attractive to government. This option has proven possible to implement relatively easily, the reason being that, to date, governments have not had to bear the burden of the consequences that result from their cost-cutting decisions. Instead, these costs have been borne largely by patients who face longer waiting times for health services.

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[183] *Ibid.*, 64:

In keeping with its philosophy that the best way to reform a complex system such as health care delivery is to introduce appropriate incentives for all the players involved, the Committee is firmly convinced that governments must be made to bear the responsibility for their decisions. Thus, the Committee believes that the blame for the waiting list problem should be placed where it belongs – on the shoulders of governments for not funding the system adequately, and jointly on governments and providers of health services, the providers for not developing clinical, needs-based waiting list management systems and governments for not demanding and funding such systems to ensure the rationality of waiting lists, including those that are attributable to underfunding. The Committee believes that governments must pay for the remedy, namely patient treatment in another jurisdiction, while waiting list management systems are being developed and put in place.

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Therefore, the Committee recommends that:

For each type of major procedure or treatment, a maximum needs-based waiting time be established and made public.

When this maximum time is reached, the insurer (government) pay for the patient to seek the procedure or treatment immediately in another jurisdiction, including, if necessary, another country (e.g., the United States). ***This is called the Health Care Guarantee.***

The Committee realizes that governments may well take the position that if a patient does not receive timely access for a medically necessary service, and hence becomes entitled to service elsewhere under the health care guarantee, the responsibility (or blame) may rest with the hospital or its physicians for not being sufficiently efficient in the use of existing resources and not managing waiting lists well enough. Under these circumstances, the government may well seek to recover the costs incurred through the care guarantee from the hospital and/or the physician(s) concerned. That is, governments may well place the responsibility for meeting the maximum waiting times on the shoulders of those responsible for actually managing the system. This is reasonable if it can be shown that underfunding is not the sole or even the primary cause of a patient waiting too long for a service.

But this is an issue to be resolved between governments and the institutions and the physicians that they fund. Patients should not be affected. Their sole concern should be to get needed treatments in a timely fashion and to have them paid for publicly. Therefore, in the first instance, governments as the patient's insurer should have the responsibility of meeting the health care guarantee.

The point at which this health care guarantee would apply for each procedure would be based on an assessment of when a patient's health or quality of life is at risk of deteriorating significantly as a result of further waiting. Waiting times would be established by scientific bodies using clinical, evidence-based criteria.

The point at which this health care guarantee would apply for each procedure would be based on an assessment of when a patient's health or quality of life is at risk of deteriorating significantly as a result of further waiting. Waiting times would be established by scientific bodies using clinical, evidence-based criteria. In order to accomplish this, the Committee recommends that:

The process to establish standard definitions for waiting times be national in scope.

An independent body be created to consider the relevant scientific and clinical evidence.

Standard definitions focus on four key waiting periods – waiting time for primary health care consultation; waiting time for initial specialist consultation; waiting time for diagnostic tests; waiting time for surgery.

The Committee recognizes that it is necessary to deal simultaneously with both sets of factors noted above. First, the techniques for effectively managing waiting lists based on sound clinical methods must be brought to bear on the management of waiting times in an efficient and equitable manner. Second, for sufficient resources to be made available so that this can happen, the political will must be there, and government must therefore have an incentive to act appropriately.

Since government has the responsibility for funding an adequate supply of essential services provided by hospitals and doctors, it has an obligation to help them meet reasonable standards of patient service. This is the essence of a patient-oriented system and of the health care "contract" between Canadians and their governments.

A maximum waiting time guarantee gives concrete form to this obligation. Were it to be implemented, such a health care guarantee would mean that government would have to shoulder the responsibility of needed care not being delivered in a timely fashion, provided, of course, the funded hospitals and physicians discharge their parts of the bargain by developing and using clinical criteria to prioritize needs-based waiting lists and by employing their resources in an optimally cost-effective manner. Allowing waiting times to increase would no longer represent a cost-free option for governments, nor for hospitals and doctors, when under-funding is not the primary reason for prolonged waiting, since they would be required to pay to have patients obtain treatment in other jurisdictions.

Other Canadian reports have made similar recommendations for dealing with waiting times. Based on a review of the Swedish experience, the report of the Premier's Advisory Council on Health in Alberta (the Mazankowski report) recommended the establishment of a care guarantee of 90 days for selected services. According to the Advisory Council, this guarantee would provide an incentive for health care providers and regional health authorities to take appropriate action to manage and shorten waiting lists. Their report stressed that patients may need to give up their preference for a specific physician or hospital if they want to be treated within the 90-day period. In addition, if regional health authorities are unable to provide service within this period, they would have to consider other options, such as getting the service from another region. Services could be provided by either a public or a private provider.

More recently, the Canadian Medical Association endorsed the Committee's health care guarantee proposal and included it in its document *A Prescription for Sustainability* issued on June 6, 2002. The CMA proposed that "guidelines and standards around quality and waiting times"[184] be established for a clearly defined basket of core services, and argued that "if the publicly funded health care system fails to meet the specified agreed-upon standards for timely access to core services, then patients must have other options to allow them to obtain this required care through other means."[185] The Committee is pleased that the CMA has adopted its proposal.

6.6 The Potential Consequences of Not Implementing a Health Care Guarantee

There are two pieces of the puzzle that must be in place in order to make significant progress in reducing waiting times, in renewing the health care contract between Canadians and their governments, and in restoring the confidence of the Canadian public in their health care system. First, governments at all levels must back their words with deeds by committing to a health care guarantee that establishes the right of Canadians to receive the care that they need in a timely manner; and second, this commitment must be applied using the best possible system for managing waiting times.

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[184] The Canadian Medical Association, *A Prescription for Sustainability*, p. 16

[185] *Ibid.*, pp. 16-17.

As the delivery of health care in Canada is a provincial responsibility, the health care guarantee must be adopted by the provinces/territories if it is to be implemented. The Committee believes that the principal way in which the federal government can contribute to the implementation of the health care guarantee is to ensure that there is agreement between the federal and provincial governments on the ways to make the financing of publicly insured health services stable and predictable. The Committee believes strongly that federal funding must be maintained at an adequate and predictable level and discusses in detail issues related to financing in Chapters Fourteen and Fifteen of this report.

Nonetheless, it is important to consider the consequences that would follow from a refusal on the part of the provinces to adopt the health care guarantee. In the preceding chapter, the Committee made the case that governments can no longer have it both ways – they cannot fail to provide timely access to medically necessary care in the publicly funded health care system and, at the same time, prevent Canadians from acquiring those services through private means. Thus, one consequence of not implementing the health care guarantee would be to render it highly likely that the current legal prohibition on the creation of a parallel private health care insurance and delivery system would be challenged successfully in the courts.

A second consequence would be that it would fall to the federal government to consider enacting its own legislation to enforce the health care guarantee. The federal government could, for example, consider setting national maximum waiting times on its own for various procedures, at the expiration of which the health care guarantee would come into effect. When a patient exceeded the maximum waiting time, the federal government could then pay the cost of treating the patient in another jurisdiction, including in the United States, and deduct the cost from the cash it transferred under the CHST to the province in which the patient resides.

Thus the penalty for violating the health care guarantee would be similar to the penalty that provinces now incur for violating the *Canada Health Act*. Currently, in cases where the federal government finds that a province has applied user charges or engaged in extra billing that are prohibited under the Act, it can withhold from the funds it would otherwise have transferred to the province an amount equivalent to what the provinces have received.

Obviously, the adoption of such legislation by the federal government would be highly contentious. However, it would ensure that a national health care guarantee of maximum waiting times came into effect – an outcome that the Committee insists must happen and that the Committee believes would also be strongly supported by the Canadian public.

6.7 Concluding Thoughts on the Health Care Guarantee

The Committee believes that it should be possible for the federal and provincial/territorial governments to reach agreement on a national set of maximum waiting times for various procedures. It passionately hopes that it will not be necessary for unilateral action to be taken by the federal government or for a parallel system of private delivery, financed by private insurance, to emerge as a result of judicial decisions. The Committee has pointed to these potential consequences of not implementing the health care guarantee only because it categorically rejects the status quo: Canadians in need of medically necessary services *must* be given *timely* access to them.

It is also important to note that the Committee's recommendation that the health care guarantee be implemented overlaps with a number of other important recommendations contained in this report. For example, health information systems and the means of evaluating performance and outcomes such as the Committee has recommended in Chapter Ten must be put in place in order to monitor waiting times across the country, so that patients receive timely treatment and the standards imposed by the health care guarantee can be monitored. In addition, the reform of primary health care delivery along the lines the Committee has proposed in Chapter Four is essential to the efficient and timely provision of health care in the twenty first century.

Part IV: Closing the Gaps in the Safety Net

CHAPTER SEVEN

EXPANDING COVERAGE TO INCLUDE PROTECTION AGAINST CATASTROPHIC PRESCRIPTION DRUG COSTS

In previous volumes, the Committee highlighted a number of critical issues with respect to prescription drug insurance coverage in Canada and the cost of prescription drugs:

- In recent years, the cost of prescription drugs has escalated faster than all other elements in health care. Spending on prescription drugs accounts for a very significant and increasing share of public sector health care expenditures. The expectation is that the upward pressures on prescription drug costs will continue as new, effective, but very costly, drugs (particularly those genetically tailored to the individual) enter the Canadian market in the next decade.
- The *Canada Health Act* does not apply to prescription drugs used outside the hospital setting, and publicly funded drug coverage varies considerably from province to province. This contrasts sharply with the policy in many OECD countries, in which publicly funded coverage is provided for prescription drugs as well as hospital and doctor services.
- Private insurance coverage for prescription drugs provided through employer-sponsored plans or individual insurance policies varies significantly in terms of design, eligibility and out-of-pocket costs to plan members.
- Despite the availability of both public and private drug insurance plans, many Canadians have no coverage at all for prescription drugs. Moreover, among those with some form of coverage (either public or private), there is substantial variation in its nature and quality.
- Financial hardship due to high prescription drug expenses is increasingly a real risk – indeed, it is a reality – for many individual and families in Canada.

This chapter reviews trends in drug costs and examines the current level of insurance coverage for prescription drugs in Canada. Particular attention is devoted to the absence and insufficiency of coverage for very high prescription drug expenses. The chapter presents the Committee's observations on Canadians' need for enhanced protection against severe or "catastrophic" prescription drug expenses, and its recommendations on how the federal government should contribute to achieving this goal.

The Committee strongly supports the view that no Canadian should suffer undue financial hardship as a result of having to pay health care bills. It is essential that this principle be applied to prescription drug expenses.

As stated in previous volumes, as well as in the present volume, the Committee strongly supports the view that no Canadian should suffer undue financial hardship as a result of having to pay health care bills. This basic principle at the root of Canadian health care policy should be applied to prescription drug expenses.

7.1 Trends in Drug Spending[186]

The Canadian Institute for Health Information reports that since 1997 spending on drugs (both prescription and non-prescription) has been the second-largest category of health care spending in Canada, behind hospitals but now ahead of spending on physician services. It is expected that final figures will show that in 2001, spending on drugs was equivalent to almost 50% of the amount spent on hospitals.

Spending on drugs has grown from $3.8 billion in 1985 to $15.5 billion in 2001. During this 16-year period, data from CIHI show that spending on drugs has grown faster than inflation and beyond the rate attributable to population growth. More precisely, from 1985 to 1992, drug expenditures increased on average by 12% annually. Between 1992 and 1996, they grew by an average of 5% annually. The growth rate then rose to around 10% in 1997 and 1998, and dropped to around 8% in 1999. Although the data have not yet been finalized, the average growth rate of drug spending is expected to have been about 7% in 2000 and 9% in 2001.

Prescription drugs make up the largest component of the total spending on drugs (79% in 2001, up from 67% in 1985). Non-prescription drugs accounted for the remaining 21% of drug spending in 2001 (compared to 33% in 1985). For the most part, non-prescription drugs are purchased directly by consumers and paid for out-of-pocket. By contrast, many payers are involved in the financing of prescription drugs. They include both the public sector (provincial/territorial Pharmacare programs, federal government plans for specific groups and Workers' Compensation Boards) and the private sector (private insurance plans and individuals).

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[186] Most of the information provided in this section is based on data from the Canadian Institute for Health Information, *Drug Expenditure in Canada, 1985-2001*, Ottawa, April 2002. The media release for this report is available on CIHI's Website at http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_24apr2002_e
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TABLE 7.1
SPENDING ON PRESCRIPTION DRUGS BY SOURCE OF FINANCE (PERCENTAGE)

	1985	1988	1999	2001
P/T Governments	40.6	42.6	38.2	42.0
Federal Government	2.3	1.9	2.4	2.4
Workers' Compensation Boards[1]	0.5	0.6	3.1	4.8
Sub-Total Public Sector	**43.4**	**45.1**	**43.7**	**49.2**
Private Insurers	N/A	30.5	33.5	29.9
Out-of-Pocket	N/A	24.4	22.8	20.9
Sub-Total Private Sector	**56.6**	**54.9**	**56.3**	**50.8**
Total All Sources	**100.0**	**100.0**	**100.0**	**100.0**

1) Data from 1997 and beyond include spending by WCBs as well as the Quebec Drug Insurance Fund.
N/A: not available.
Source: CIHI (April 2002), *Drug Expenditure in Canada, 1985-2001*, and Economics Division, Parliamentary Research Branch, Library of Parliament.

In 1985, 57% of prescription drug spending came from the private sector (see Table 7.1). By 2001, it had decreased to 51%. Correspondingly, the share of prescription drugs financed from public sources increased steadily from 43% to 49%. Table 7.1 also shows that the total proportion of prescription drugs paid out-of-pocket by individual Canadians has decreased from 24.4% in 1988 to 20.9% in 2001. That is, an increasing share of total prescription drug spending in Canada is being picked up by public sector drug coverage plans.

CIHI data on drug spending do not include drugs dispensed in hospitals, which it classifies as hospital expenditure. Estimates provided by CIHI in its April 2002 report suggest that drug expenditures in hospitals amounted to $1.1 billion in 2001. In addition, the share of total hospital expenditures spent on drugs has consistently increased between 1985 and 2001, from 2.8% to 3.4%. CIHI notes, however, that the rate of growth in drug expenditures in hospitals has been slower than that of out-of-hospital drug spending. Although there may have been some shift in drug spending from hospitals to the community, CIHI stresses that more research is required to examine the relationship between drug utilization in and out-of-hospital.

Many observers expect out-of-hospital costs of prescription drugs to grow substantially in the coming years, for a number of reasons:

- The cost of developing and marketing new drug therapies has risen rapidly as pharmaceutical companies tackle more challenging diseases and face more stringent drug approval processes around the world.
- Rapid scientific progress has introduced the possibility of developing new genetically tailored drugs, applicable to a small number of patients suffering with chronic degenerative conditions, that are potentially extremely effective and also enormously costly.

- Many of the newer drug therapies are targeted at chronic conditions treated at home, as opposed to acute conditions treated in hospital.
- Changes in medical practice and new technology have replaced some hospital-based treatment with home care, which is now being provided for a number of conditions with high drug therapy costs.

The net effect is that many Canadians now incur high levels of prescription drug costs that were inconceivable only a few years ago.

7.2 International Comparisons

In comparison to selected OECD countries, Canada allocates a large proportion of its total health care spending to drugs, ranking second in 1998 to the United Kingdom. In the same year, Canada ranked fourth for the level of drug spending per capita, after the United States, Germany and Sweden. Spending on drugs varies greatly across countries and is influenced by numerous factors, including specific public policy traditions and institutional characteristics (reimbursement systems for users and providers, prescribing habits, etc.).[187]

Many Canadians now incur high levels of prescription drug costs that were inconceivable only a few years ago.

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[187] Stephane Jacobzone, *Pharmaceutical Policies in OECD Countries: Reconciling Social and Industrial Goals*, Occasional Paper No. 40, Labour Market and Social Policy, OECD, April 2000 (www.oecd.org).

TABLE 7.2
PUBLIC INSURANCE COVERAGE FOR PRESCRIPTION DRUGS

	Formulary	Cost Sharing
Australia	▪ National formulary listing only drugs that receive a positive assessment with respect to safety, quality, clinical efficacy and cost-effectiveness. ▪ Therapeutic reference-based pricing.[1]	▪ Fixed co-payment per prescription, subject to an annual ceiling. Co-payment varies by type of beneficiary. ▪ Exemptions for some segments of the population. ▪ Higher cost sharing for brand-name drugs when generic copies are available. ▪ Individuals must pay for drugs not listed on the formulary.
Germany	▪ The federal government maintains a "negative list" of drugs that are not entitled to public reimbursement. ▪ Therapeutic reference-based pricing.[1]	▪ Fixed co-payment per prescription. Co-payment varies by type of beneficiary and size of prescription.
Netherlands	▪ National formulary. ▪ Therapeutic reference-based-pricing.[1]	▪ Fixed co-payment per prescription, subject to an annual ceiling. Co-payment varies by type of beneficiary. ▪ Exemptions for some segments of the population.
Sweden	▪ There is no national formulary, but each county council has developed its own list. ▪ All drugs prescribed by doctors and hospitals are purchased by a single national agency, Apotekbolaget, a state-owned company that owns all pharmacies in Sweden..	▪ Fixed co-payment per prescription, subject to an annual ceiling. Co-payment varies by type of beneficiary. ▪ Exemptions for some segments of the population.
United Kingdom	▪ National formulary under the NHS. ▪ There is also a negative list , that excludes some drugs from NHS prescription on the grounds of poor therapeutic value or excessive cost.	▪ Fixed amount per prescription. ▪ Exemptions for some segments of the population.

1) Therapeutic reference-based pricing ensures that the government pays only up to the price of a lower-priced drug that is therapeutically interchangeable with, or equivalent to, the prescribed drug.
Source: Stephane Jacobzone, *Pharmaceutical Policies in OECD Countries: Reconciling Social and Industrial Goals*, Occasional Paper No. 40, Labour Market and Social Policy, OECD, April 2000; Donald Willison et al., *International Experience with Pharmaceutical Policy: Common Challenges and Lessons for Canada*, Project funded under Health Canada's Health Transition Fund, 30 April 2001; Senate Committee on Social Affairs (Volume Three); and Economics Division Parliamentary Research Branch, Library of Parliament.

In contrast, Canada and the United States exhibit a much lower public share of spending on drugs, which is largely explained by the fact that the entire population of other countries is covered for prescription drugs by public insurance. Also, the countries with which Canada and the United States are compared have formularies restricting the number of drugs covered under public insurance, and they impose cost sharing (co-payments, co-insurance and deductibles) with waivers for certain groups of beneficiaries (see Table 7.2).

7.3 Coverage for Prescription Drugs in Canada[188]

Currently, coverage for prescription drugs in Canada is offered through a mixture of public and private insurance plans described briefly below.

7.3.1 Public prescription drug insurance plans

With respect to public plans it is worth noting that:

1. All provinces have public prescription drug programs that cover virtually all the drug costs of low-income seniors (those receiving GIS, the Guaranteed Income Supplement), a group that constitutes about 5% of Canada's adult population. This group is thus fully protected from catastrophic prescription drug expenses. All provinces except Newfoundland also offer coverage to higher-income seniors as well.

2. All provinces also have programs that provide prescription drug coverage for recipients of social assistance, a group that comprised 6.8% of the population in 2000, protecting them also from catastrophic prescription drug expenses.

3. The federal government assumes the full cost of providing prescription drugs (as well as other health services) for some Aboriginal populations and certain armed forces veterans. These groups, which account for approximately 2% of the Canadian population, are thereby fully protected against catastrophic prescription drug expenses.

4. Provincial governments in British Columbia, Saskatchewan, Manitoba, and Ontario have prescription drug plans targeted to the general population that provide a protective cap (in some cases based on family income) on the personal cost of drug expenses borne by individuals.

5. Quebec mandates prescription drug coverage with an out-of-pocket cap no greater than $750 for all residents, whether under employer-sponsored programs or the provincial program.

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[188] This section is based on information provided by Fraser Group/Tristat Resources, *Drug Expenses Coverage in the Canadian Population: Protection From Severe Drug Expenses*, August 2002. This study was sponsored by the Canadian Life and Health Insurance Association at the request of the Committee.

6. Alberta offers to all residents a public, voluntary, premium-based prescription drug insurance plan that provides significant drug expense coverage after a three month waiting period.

In summary, a significant number of public drug plans provide a significant degree of protection against personal financial hardship to Canadians who face very high expenses for prescription drugs. However, the federal government does not directly contribute to any of the provincial plans.

7.3.2 Private prescription drug insurance plans

Private sector drug insurance plans contribute significantly to Canadians' prescription drug coverage:

1. They are an entirely voluntary initiative, sponsored mostly by employers but also by unions, joint union/employer entities and educational institutions. In addition, about 1% of Canadians are covered by health insurance policies purchased individually.

2. An estimated 2.4 million Canadians belong to private-sector plans that cover 100% of prescription drug expenses, thus completely protecting their members from financial hardship attributable to very high drug costs. An additional 300,000 have plans that, in combination with public prescription drug coverage, provide 100% coverage.

3. An estimated 9.7 million Canadians (the 2.4 million mentioned above plus an additional 7.3 million Canadians, totalling 55% of those in private-sector plans) have private-sector plans that include an overall protective cap on the out-of-pocket costs of individual plan members.

4. The remaining 8.1 million Canadians in private-sector plans (45% of those in private-sector plans) have coverage that, for the most part, provides substantial – but not complete – protection from catastrophic prescription drug expenses.

In Volume Four, the Committee recounted the real-life experience of one Atlantic Canadian whose experience illustrated this last point. A professional librarian and member of a good-quality employer-sponsored plan, the individual in question faced personal out-of-pocket costs of $17,000 annually attributable to his wife's requirement for prescription drugs that cost $50,000 a year.

The Committee recently heard of another Atlantic Canadian resident whose medication for pulmonary hypertension (a life-threatening condition) costs more than $100,000 a year. The individual in question's current expenses are over $4,600 monthly (or $55,000 annually) in order to cover the insurance premium, the drug, the peripherals needed to administer the drug, additional necessary medications and oxygen tanks. An anticipated increase in dosage within the next year will increase the monthly bill to approximately $5,150, or $61,800 annually. People become eligible for government assistance in this province only once they have exhausted all their savings, including RRSPs.

7.3.3 Plan features and their relation to protection from severe drug expenses

While prescription drug insurance plans have many different features and attributes, only four relate to the extent of protection such plans offer against catastrophic drug expenses. These are: deductibles, co-payments/co-insurance, annual or lifetime maximums, and out-of-pocket caps.

A *deductible* is the amount of drug expense that must be paid initially by an individual before the drug insurance plan reimburses any expense. The deductible is normally applied to a calendar or plan year. Deductibles are commonly expressed as fixed dollar amounts, but some legislated public drug insurance programs use amounts related to family income. Deductibles, unless they are extraordinarily high, usually have minimal impact on the degree of protection a plan provides against catastrophic drug expenses.

Co-payments and co-insurance correspond to the portion of the cost of each prescription that must be paid by the individual. Co-payments take the form of a flat amount per prescription (e.g., $5), while co-insurance requires a fixed percentage per prescription (e.g. 5%). Co-payments can also include the pharmacist's professional dispensing fee (as opposed to the cost of the drug itself). They do not protect individuals, as in the professional librarian example cited above, from very high personal expenses resulting from the prolonged use of very expensive drugs.

An annual or lifetime maximum restricts to a specific amount the total amount of prescription drug expenses that a plan will pay on behalf of a plan member. Expenses in excess of this amount are to be paid out-of-pocket. For instance, a plan with a $5,000 annual maximum would pay no more than that in a given year. The higher the maximum, the greater the protection. It is highly unusual for public prescription drug insurance plans to impose maxima. Some private-sector plans do, but most have unlimited coverage or specify very high annual or lifetime maxima such as a million dollars.

Finally, *out-of-pocket caps* are provisions of plans that restrict the total amount of deductibles, co-payments and co-insurance to be imposed on an individual during a given year. These may be expressed either as a fixed upper limit (e.g., $1,500) or as an amount related to family income (e.g., 3%). Many prescription drug insurance plans, particularly private-sector plans, do not have explicit caps on out-of-pocket drug expenses. This feature in a drug plan guarantees the insured individual protection against catastrophic prescription drug expenses. The lower this limit, the higher the degree of protection.

7.4 An Emerging Issue: Catastrophic Prescription Drug Expenses

Generally, the direct financial impact of the rise in drug spending described above is relatively modest because the proportion of average household expenditures spent on prescription drugs remains small in absolute terms. CIHI data show that in 1999 the annual per capita expenditure on prescription drugs was $331.38, of which $75.49 was paid for out-of-pocket.

Nonetheless, some individuals and families can and *do* incur much more substantial expenses. While it is important to recognize that this affects relatively few people for the moment, the Committee believes that the problem warrants careful attention because:

1. Most important, some individuals do experience substantial personal financial hardship in paying for drug expenses, thereby frustrating the fundamental objective of Canadian health policy referred to above.
2. Those facing a significant personal financial burden may discontinue (or not begin) treatment requiring expensive medications.
3. Physicians may admit patients to more costly hospital based treatment so they are spared the high costs for drugs dispensed for use out of hospital.
4. Doctors may prescribe and patients may demand cheaper but less effective drugs.
5. Individuals may stay on social assistance rather than seek employment in order to maintain drug coverage.
6. The drug plan to which the affected individual belongs may experience sufficient financial expenditures that it prompts the plan sponsor to limit or discontinue it, thereby reducing or eliminating drug expense protection for all members of the plan. Other drug plan sponsors may take pre-emptive action to reduce the financial risk of catastrophic drug costs to their own plans

Estimates by Fraser Group/Tristat Resources show that currently 98% of the Canadian population is covered by one or more public and/or private prescription drug coverage plans (see Table 7.3). Two percent of Canadians (some 600,000 individuals) have no prescription drug coverage whatsoever and must assume full personal financial exposure in the event they require expensive prescription drugs.

Two percent of Canadians (some 600,000 individuals) have no prescription drug coverage whatsoever and must assume full personal financial exposure in the event they require expensive prescription drugs.

TABLE 7.3
PRESCRIPTION DRUG EXPENSE COVERAGE IN THE CANADIAN POPULATION

Covered by	Percent of Population
Public Plans	53%
Private Plans	58%
Both Public and Private	13%
No Coverage	2%

Source: Fraser Group/Tristat Resources, Drug Expense Coverage in the Canadian Population: Protection From Severe Drug Expenses, August 2002, p. 11.

Fraser Group/Tristat Resources also analyzed the variations in the current levels of protection from severe drug expenses by province. Tables 7.4 and 7.5 show the percentage of the population of each province that would face various levels of out-of-pocket expenses when confronted with total prescription drug expenses of either $5,000 (Table 7.4) or $20,000 (Table 7.5). Each table divides the population of the province into four groups according to how much they would each pay out-of-pocket: (a) those who would pay up to $750; (b) those who would pay between $751 and $2,000; (c) those who would pay over $2,000; (d) those with no coverage at all.

Thus, for example, Table 7.4 indicates that 70% of B.C. residents with drug expenses of $5,000 pay no more than $750 out of pocket, while the remaining 30% of B.C. residents pay between $751 and $2,000. In Newfoundland, only 48% of the population who spend $5,000 on prescription drugs pay up to $750, while 24% of population of that province pay between $751 and $2,000. However, there are also 28% of Newfoundlanders who have no coverage at all and therefore have to pay the full $5,000.

For those with $20,000 in prescription drug expenses (Table 7.5), the percentages of B.C. residents with each level of out of pocket expenses remain the same. In Newfoundland, 48% of the population still pay only up to $750, and the same 28% of the population have no coverage and must pay the full $20,000. The 24% of the population that paid between $751 and $2,000 when faced with drug expenses of $5,000, now has to pay over $2000.

While the lack of coverage for a substantial proportion of Atlantic Canada residents remains a striking feature of the national pattern, the tables also point to significant variations in out-of-pocket levels among provinces that have programs covering their entire population. Quebec stands out as having the least variation in protection levels, followed by British Columbia, Manitoba and Saskatchewan.

TABLE 7.4
OUT-OF-POCKET COSTS FOR PRESCRIPTION DRUG EXPENSES OF $5,000 (PERCENTAGE OF POPULATION)

	Up to $750	$751 - $2,000	Over $2,000	No coverage	Total
BC	70%	30%	0%	0%	100%
ALTA	43%	57%	0%	0%	100%
SASK	68%	24%	8%	0%	100%
MAN	84%	13%	3%	0%	100%
ONT	70%	25%	5%	0%	100%
QC	100%	0%	0%	0%	100%
NB	45%	28%	0%	27%	100%
NS	47%	29%	0%	24%	100%
PEI	48%	25%	0%	27%	100%
NFLD	48%	24%	0%	28%	100%
Canada	**73%**	**23%**	**2%**	**2%**	**100%**

TABLE 7.5
OUT-OF-POCKET COSTS FOR PRESCRIPTION DRUG EXPENSES OF $20,000 (PERCENTAGE OF POPULATION)

	Up to $750	$751 - $2,000	Over $2,000	No coverage	Total
BC	70%	30%	0%	0%	100%
ALTA	43%	0%	57%	0%	100%
SASK	67%	25%	8%	0%	100%
MAN	84%	13%	3%	0%	100%
ONT	70%	12%	18%	0%	100%
QC	100%	0%	0%	0%	100%
NB	45%	0%	28%	27%	100%
NS	47%	0%	29%	24%	100%
PEI	48%	0%	25%	27%	100%
NFLD	48%	0%	24%	28%	100%
Canada	**73%**	**20%**	**5%**	**2%**	**100%**

Source: Fraser Group/Tristat Resources, Drug Expense Coverage in the Canadian Population: Protection From Severe Drug Expenses, August 2002, pp. 48-49.

Data from the same group also indicate that coverage for the great majority of Canadians (89%) provides a protective cap on out-of-pocket costs regardless of the amount of high prescription drug expenses. However, 9% of the Canadian population have drug coverage plans without such protective caps, that require co-payments or have reimbursement limits. For these individuals, out-of-pocket costs increase as their prescription drug expenses increase.

In total, 11% of Canadians are at substantial risk of significant financial hardship from high prescription drug expenses paid out of their own pockets. Table 7.6 illustrates the out-of-pocket costs for an individual requiring prescription medications costing $20,000 per year.[189]

TABLE 7.6

Plan Type	Plan Parameters		Out-of-Pocket Cost ($)
	Deductible	Co-payment	
A common employee benefit plan	0	0	0
Social assistance in many provinces	0	0	0
Indian Affairs NIHB	0	0	0
Another common employee benefit plan	$25	0	25
Alberta Seniors Plan	0	30% not to exceed $25 per prescription	About 900 (assuming 3 prescriptions per month
Quebec RAMQ for individuals under age 65	$100	25% out-of-pocket (capped at $750)	750
British Columbia Pharmacare	$800	0	800
Ontario Trillium Plan (for family income of $60,000)	4% of adjusted family income		2,400
Most common employee benefit plan	0	20%	4,000
Federal Civil Service	$60	20%	4,048
Alberta Non-Group Program	0	30%	6,000
No Coverage	N/A	N/A	20,000

In a separate analysis of claims data from a large number of employer sponsored drug plans (approximately half of all plans in Canada), research presented to the Committee showed that for the year 2000:

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[189] While this is not a common occurrence, approximately 4,000 individuals in private plans exceeded this level of expense in 2000. A comparable figure for public plans is not available.

- A few individuals had drug expenses exceeding $200,000.
- About one person per thousand insured had personal medical expenses (supplemental to medicare) exceeding $10,000. The great majority of these expenses were for prescription drugs.

From these data, it is estimated that some three persons per thousand or about 53,000 persons covered by private-sector plans experienced drug expenses exceeding $5,000 in the year 2000.

It is possible to say, therefore, with some confidence that more than 100,000 Canadians experience annual drug expenses exceeding $5,000; that number is virtually certain to increase in the years ahead.

Published data from the Ontario Drug Benefit program suggest that the frequency of drug expenses exceeding $5,000 may be several times higher (between 10 and 20 per thousand) within public plans covering seniors and those unable to work. This is not particularly surprising since public plans cover all seniors, who represent the age segment of the population most likely to make high use of prescription drugs.

It is possible to say, therefore, with some confidence that more than 100,000 Canadians experience annual drug expenses exceeding $5,000; that number is virtually certain to increase in the years ahead. How these heavy expenses are paid – that is, how much is paid by a private insurance plan, how much by a public insurance plan and how much by the individual out-of-pocket – will, of course, vary from individual to individual.

7.5 Protecting Canadians Against Catastrophic Prescription Drug Expenses

In developing its proposal to expand the federal government's role in health care to include protection against the impact of severe or "catastrophic" prescription drug expenses, the Committee has sought to accomplish two objectives.

First, and foremost, the Committee wants to make sure that no Canadian individual or family is exposed to undue financial hardship as a result of having to pay all, or even a significant fraction, of the costs of extremely expensive and/or prolonged prescription drug treatments. This is entirely consistent with the basic public policy objectives underpinning the system of public health care insurance in Canada.

Second, the Committee wants to create the conditions for long-term sustainability of current prescription drug coverage programs, both provincial public and private supplementary drug insurance plans, in the face of escalating prescription drug costs and the anticipated introduction of increasingly expensive and effective drug therapies.

Specifically, the Committee's proposal calls for the federal government to take over responsibility for 90% of prescription drug expenses that exceed a certain limit that qualifies them as "catastrophic."

The Committee's proposed plan therefore builds on, rather than replaces, Canada's extensive current systems of provincial prescription drug coverage and private supplementary drug insurance plans. The Committee's intent, therefore, is to present a feasible and realistic program that will inject new federal money into expanding available coverage in ways that will protect Canadians against undue financial hardship resulting from severe or catastrophic prescription drug expenses.

Specifically, the Committee's proposal calls for the federal government to take over responsibility for 90% of prescription drug expenses that exceed a certain limit that qualifies them as "catastrophic." The federal government should establish criteria and conditions that private and provincial/territorial public plans would have to meet to be eligible to receive this federal assistance. In exchange, the federal government would assume 90% of the expense of protecting Canadian individuals and families against catastrophic drug expenses. In order to ensure uniformity of coverage throughout the country, and in order to be able to control which drugs are eligible to be covered under this program, it will also be necessary to establish a national drug formulary (see section 7.6, below).

In order to ensure uniformity of coverage throughout the country, and in order to be able to control which drugs are eligible to be covered under this program, it will also be necessary to establish a national drug formulary.

The Committee is aware that the final parameters of the catastrophic prescription drug insurance plan would have to be established through negotiations between all the concerned parties – the federal and provincial/territorial governments as well as supplementary drug plan sponsors and carriers. However, the Committee feels that the basic contours of the plan it has worked out constitute a realistic and acceptable framework for implementation.

7.5.1 How the plan would work

To qualify for federal assistance, provinces/territories would have to put in place a program that would ensure that residents of the province/territory would never be obliged to pay out-of-pocket more than 3% of their family income for prescription drugs. That is, personal prescription drug expenses for any family of the province/territory would be capped at 3% of the individual's total family income. The federal government would agree to pay 90% of prescription drug expenditures in excess of $5,000 for individuals for whom the combined total of their out-of-pocket expenses and the provincial contribution for which they were eligible was greater than $5,000 in a single year. Thus, the participating provincial/territorial governments would have to pay only 10% of the cost that exceeded $5,000 of supplying prescription drugs to families who incurred catastrophic drug expenses (i.e., those whose total drug expenses exceeded $5,000 for the year).

To qualify for federal assistance, provinces/territories would have to put in place a program that would ensure that residents of the province/territory would never be obliged to pay out-of-pocket more than 3% of their family income for prescription drugs.

To qualify for federal assistance, sponsors of private supplementary prescription drug insurance plans would have to guarantee that no individual plan member would be obliged to incur out-of-pocket expenses that exceed $1,500 per year. That is, for private-sector plans, out-of-pocket costs for plan members would be capped at $1,500 in any given year. For plans that meet this criterion, the federal government would then agree to pay 90% of prescription drug costs in excess of $5,000 for individual plan members whose total prescription drug costs exceed $5,000 per year, with the plan paying the remaining 10%. Thus, each individual plan member's out-of-pocket costs would be capped at either 3% of family income or $1,500, whichever is less.

To qualify for federal assistance, sponsors of private supplementary drug insurance plans would have to guarantee that no individual plan member would be obliged to incur out of pocket expenses that exceed $1500 per year. Private supplementary drug plans would retain responsibility for drug expenses up to $5000.

Private supplementary drug plans would retain responsibility for drug expenses up to $5,000, and would be strongly encouraged to put in place a pooling mechanism to assist all plans in dealing with costs in the $1,500 – $5,000 range. Private plan sponsors would, of course, be able to offer additional benefits and enhancements beyond the minimum requirements to be eligible for federal assistance.

The net result of this new program to protect Canadian individuals and families against the consequences of severe prescription drug expenses would be that no one would ever be obliged to pay more than 3% of their family income for prescription drugs. Those who are members of a private plan that participates in the federal program would never pay more than $1,500 or 3% of their family income for prescription drugs, whichever is lower. Depending on whether or not an individual is a member of a private plan, the first $5,000 in total prescription drug expenses would be paid by some combination of individual out-of-pocket spending, public and private insurance. The federal government would then pay 90% of the prescription drug costs over $5,000 incurred by any individual in the course of a single year, with the remaining 10% of the costs over $5,000 being paid by either a provincial or a private supplementary plan.

To illustrate how this program would work in practice, consider the following example. Three individuals each incur $10,000 in prescription drug expenses in the course of a given year. One of them, Jane, earns $60,000 annually. Another, Bob, earns $30,000. Both Jane and Bob are enrolled in supplementary private insurance plans that meet the federal eligibility criteria for catastrophic prescription drug coverage. The third, Anne, is self-employed and also earns $60,000 a year, but does not have private supplementary drug insurance. All three live in a province that participates in the federal plan.

In Anne's case, she would seek assistance from the provincial prescription drug insurance plan. Since 3% of Anne's income is $1,800, she would be entitled to receive $8,200 from the provincial plan to meet her total cost of $10,000.

In Bob's case, his out-of-pocket expenses would be capped at $1,500 under his private supplementary drug insurance plan. However, 3% of his income is only $900. Bob would therefore be entitled to a $600 rebate from his insurance plan, so his total out-of-pocket expenditure does not exceed 3% of his income.[190]

In Jane's case, her out-of-pocket expenses would, like Bob, be capped at $1,500 by her private supplementary plan, but since 3% of her income ($1,800) is greater than her out-of-pocket costs ($1,500), she would not be entitled to additional assistance.

Let's now suppose that Jane and Bob get married. They still each incur $10,000 in prescription drug expenses annually, for a total of $20,000. Their family income is now $90,000 ($60,000+$30,000). Their private supplementary insurance plan caps their out-of-pocket expenses at $1,500 each, for a total of $3,000. However, 3% of their family income is only $2,700. Jane and Bob, therefore, are entitled to receive a $300 rebate from the provincial government.

The federal government's contribution would be paid either to the provinces or to the supplementary private insurance plans, but not directly to individuals. These payments would be made at regular pre-determined intervals (quarterly, semi-annually or annually) and claims submitted to the federal program would, of course, be subject to periodic audit to ensure that they corresponded to expenses that were actually incurred.

7.5.2 The benefits of the plan

Taken together, these measures would provide effective protection against catastrophic prescription drug expenses for all Canadians and offer additional benefits to those with lower incomes by capping out-of-pocket expenses at 3% of family income. The plan also contains incentives for both the provincial/territorial governments and private supplementary plan sponsors to participate.

For the provinces and territories, the Committee's plan is structured so that the federal government provides financial assistance for some coverage that all provinces/territories already offer, such as paying the costs of catastrophic prescription drug expenses of seniors and people on social assistance. The federal contribution would therefore free up provincial money and enable provinces to pay for whatever improvements to provincial prescription drug plans are required to put in place the guarantee that no resident incur out-of-pocket costs in excess of 3% of his/her income. Furthermore, it shifts the onus from the provinces to the federal government to deal with the increasing incidence of very high (catastrophic) drug costs attributable to escalation in the cost of drugs themselves and the introduction of new, more sophisticated, and particularly expensive drug therapies.

The net result would be, of course, a real step forward for those Canadians (roughly 600,000 people) who currently have no protection whatsoever against catastrophic prescription drug expenses.

Thus, even those provinces/territories that do not currently provide any coverage against catastrophic expenses for the working population under the age of 65 (and that might also have difficulty participating in a traditional federal cost-sharing program because of a lack of available provincial money to match the federal dollars) are likely to derive sufficient financial benefit under this program to allow them to meet the federal eligibility criterion. The net result would be, of course, a real step forward for those Canadians (roughly 600,000 people) who currently have no protection whatsoever against catastrophic prescription drug expenses.

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[190] Note that it should be possible to work out a payment plan that enables people who are not in a position to wait for a rebate from the government at the end of the year to benefit from a credit at the point of purchase, or some similar scheme to reduce their actual out of pocket expenses to a manageable limit.

The Committee's proposal would also help ensure the long-term sustainability of private supplementary drug insurance plans for those that agree to cap their members' out-of-pocket expenses at $1,500 per year. It would remove the spectre of extreme volatility in plan costs due to catastrophic drug expenses. Moreover, potential plan sponsors who have hesitated to adopt supplementary prescription drug benefit plans in the past out of fear of potentially facing catastrophic drug costs may now be more inclined to introduce them. This is particularly important for small and new businesses, enabling them to offer more competitive benefits packages to prospective employees than would otherwise be possible.

7.5.3 How much would the plan cost?

It is estimated that implementing this federal initiative to protect all Canadians against catastrophic prescription drug costs would cost approximately $500 million per year. At the request of the Committee, this cost estimate was prepared using a large-scale micro-simulation model of national drug coverage constructed by the Fraser Group and Tristat Resources, researchers who have authored several major studies of prescription drug coverage in Canada. Their most recent study, *Drug Expense Coverage in the Canadian Population: Protection from Severe Drug Expenses*, was presented to the Senate Committee on June 12, 2002.

The model by the Fraser Group and Tristat Resources is built on four key data files:

- The Statistics Canada Survey of Labour Income Dynamics (SLID) sample of approximately 60,000 Canadian households provides the basic demographic characteristics.
- The Statistics Canada Survey of Work Arrangements is used to establish supplementary drug coverage status.
- The Plan Parameter File, which establishes the terms of the public and private plans, was developed from an analysis of public plan provisions and records of 80,000 employer-sponsored plans.
- The Drug Need File, containing the estimated average annual drug expense for each age and gender group as well as the probability distribution by size of expense, is based on an analysis of supplementary drug plan claims data as well as published data from some public programs.

The entire model is balanced to aggregate benchmarks derived from macro statistics provided by the Canadian Institute for Health Information for the year 2000, adjusted for the characteristics of the sample frame used by the Statistics Canada surveys.

The Committee has added an additional cushion to the raw output from the model with a view to providing a prudent and robust estimate that is believed to overestimate somewhat the likely costs.

7.5.4 Committee's Proposal for a Catastrophic Prescription Drug Insurance Plan

In summary, then, the Committee recommends that:

The federal government introduce a program to protect Canadians against catastrophic prescription drug expenses.

For all eligible plans, the federal government would agree to pay:

- **90% of all prescription drug expenses over $5,000 for those individuals for whom the combined total of their out-of-pocket expenses and the contribution that a province/territory incurs on their behalf exceeds $5000 in a single year;**
- **90% of prescription drug expenses in excess of $5,000 for individual private supplementary prescription drug insurance plan members for whom the combined total of their out-of-pocket expenses and the contribution that the private insurance plan incurs on their behalf exceeds $5,000 in a single year.**
- **the remaining 10 % would be paid by either a provincial/territorial plan or a private supplementary plan.**

In order to be eligible to participate in this federal program:

- **provinces/territories would have to put in place a program that would ensure that no family of the province/territory would be obliged to pay more than 3% of family income for prescription drugs;**
- **sponsors of existing private supplementary drug insurance plans would have to guarantee that no individual plan member would be obliged to incur out-of-pocket expenses that exceed $1,500 per year; this would cap each individual plan member's out-of-pocket costs at either 3% of family income or $1,500, whichever is less.**

7.6 The Need for a National Drug Formulary

It is clear to the Committee that, in order to implement its plan to protect Canadian individuals and families from catastrophic prescription drug costs in a uniform and equitable manner across the country, it will be necessary to establish a national drug formulary. The concept of a national drug formulary was brought to the Committee's attention by a number of witnesses during its study.

A drug formulary refers to a list of prescription drugs that are supplied under public drug insurance plans. A "national" drug formulary does not mean that the federal government alone would be responsible for determining which prescription drugs would be on it. Rather, a national formulary is best conceived in terms of harmonization among the federal, provincial and territorial participants together with the participation of other interested stakeholders.

As the Committee noted in Volume Four of its study, the benefits of a national drug formulary include the following:

- Elimination of the potential for log-rolling, or pressuring one province to add a drug to its formulary because another has already done so;
- Enhanced ability to undertake and make available nationally the research needed to understand whether the benefits of a new (and costlier) drug genuinely represent a significant improvement on existing (and cheaper) drugs.[191]

The establishment of a national drug formulary could lead the way to the creation of a single national buying agency – one that covers all provincial/territorial/federal jurisdictions. The substantial buying power of such an agency would strengthen the ability of public prescription drug insurance plans to negotiate the lowest possible purchase prices from drug companies.

Given the plan to protect Canadians against catastrophic prescription drug costs, a national drug formulary would mean that all Canadians would receive comparable coverage and access to drugs regardless of where they lived. It would also enable the funders of the program to exercise control over which drugs were eligible for coverage. The Committee believes that, since the federal government will be funding 90% of the cost, it is essential that the federal government be at the table when these decisions are made. Moreover, given the potential for exponential growth in the costs of new drug therapies, the funders of the program will have to agree jointly which drugs are covered under the plan. The Committee therefore recommends that:

The federal government work closely with the provinces and territories to establish a single national drug formulary.

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[191] Volume Four, p. 71.

CHAPTER EIGHT

EXPANDING COVERAGE TO INCLUDE POST-ACUTE HOME CARE

8.1 Brief Review of Key Points about Home Care from Volumes Two and Four

Spending on home care in Canada (both public and private) has increased continually over the past two decades (see Figures 8.1 and 8.2). In previous Volumes, the Committee noted that there is no consensus about what services should be included in the definition of home care. Home health care services can cover some acute care (intravenous therapy and dialysis, for example), long-term care (for individuals with degenerative diseases such as Alzheimer's or chronic physical or mental disabilities), and end-of-life care for those with terminal conditions. In addition to health care, home care can include social support services such as monitoring, homemaking, nutritional counselling and meal preparation. It extends along a wide continuum of care.

There are two basic kinds of home care providers: formal caregivers such as nurses, therapists, and personal support workers; and informal caregivers, usually family members or friends. The 1998/99 Population Health Survey found that the majority of those who reported needing care in the home due to aging, chronic illness or disability received no formal, publicly funded care whatsoever. Between 80% and 90% of all home care provided to people with these needs is unpaid. The survey did not report the extent to which needs not paid for from public funds are being paid for privately, met by informal caregivers, or simply not met.

The need for home care will become a major challenge as the baby boomers age, average life expectancy rises, health care delivery becomes both more de-institutionalized and more technologically complex, and as work and social patterns decrease the availability of informal care-giving by family members.

The need for home care will become a major challenge as the baby boomers age, average life expectancy rises, health care delivery becomes both more de-institutionalized and more technologically complex, and as work and social patterns decrease the availability of informal care-giving by family members. The Committee heard that home care can fulfill a number of functions, notably:

- it substitutes for services provided by hospitals and long-term care facilities;
- it maintains clients' capacity to remain in their current environment, usually their homes, as an alternative to moving to another and often more costly venue such as a long-term care facility; and
- it reduces dependency, primarily by providing monitoring at additional short-run but lower long-run costs.

Many witnesses contended that when home care is substituted for acute care – usually hospital-based care – it should be considered the same as acute care delivered in other settings and, accordingly, should be encompassed under the *Canada Health Act*.

Currently, each province and territory offers some form of home care program, but not as a "medically necessary" service under the *Canada Health Act*. Therefore, publicly funded home care programs vary greatly across the country in terms of eligibility, scope of coverage and applicable user charges. Although its provision has increased in most provinces in recent years, public spending on home care still represents a small proportion of overall provincial health care budgets.

Recent studies suggest that although home care is generally cost-effective, it is clear that in many cases institutionalized care remains more efficient, particularly for the frail elderly. Of course, institutionalized care is always more convenient for service providers.

But cost and the ease of service delivery are not the only factors to be taken into account. Many people want to receive care if it is available to them in their homes, rather than in institutions.

In Volume Four (section 8.10), the Committee outlined four options for federal contributions to the financing of home care:

1. *A National Home Care Program*

Under this option, the federal government would increase its transfers to assist the provinces and territories to develop home care programs in their respective jurisdictions. The federal government would work closely with the provinces and territories to develop national home care standards, a critical issue if home care is to become a fully integrated component of Canada's health care delivery system.

2. *Tax Credit and Tax Deduction to Home Care Consumers*

The federal government could offer enhanced financial assistance to home care consumers through tax changes that build upon existing income tax provisions. Alternatively new tax incentives could be created to encourage people to put money aside for their long-term care needs.

3. *Creating a Dedicated Insurance Fund to Cover the Need for Home Care*

Using a dedicated, capitalized insurance fund approach such as that suggested by the Clair Commission in Quebec, home care could be offered as benefits in kind or as monetary benefits.

4. *Specific Measures Aimed at Informal Caregivers*

The reduction in in-patient hospital services has increased the burden of care on families and friends of home care patients. Currently, more than 3 million Canadians – mostly women – provide unpaid care to ill family members in the home. This option would provide further financing support for Canada's informal caregivers, using the Canada Pension Plan (CPP) and/or Employment Insurance programs to assist those who leave the workforce temporarily to provide informal care.

8.2 Other Options

These options were focused on federal involvement in all three aspects of home care (substitution, maintenance and prevention). The only specific aspect that was raised in Volume Five was in relation to the development of a national health info-structure and concerned the need to invest in tele-homecare. In Volume Five, the Committee also announced its intention to produce a thematic study on the issue of home care in the near future.

In subsequent testimony, the Committee heard that it is important to consider devising a national home care strategy in stages, beginning with the function of home care as a substitute for acute care.

Health Canada showed in 1999[192] that on a national basis, one-third of home care's clientele has acute needs and two-thirds employ its long-term services (Table 8.1). The latter are recipients of continuing care, while the former are post-acute care recipients, usually those requiring services for a short period following hospitalization. Recent hospital transformations through closures, mergers, reductions in lengths of stay, and changes to the size and function of hospitals have shifted the traditional home care caseload, putting greater emphasis on post-acute home care recipients.

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Home care is no longer the preserve of the elderly. Forty-five percent of home care recipients in Ontario are under 65 years of age and 15 percent are children.[193] Moreover, the services profiles are distinct for the two main groups of home care clients. The post-acute care group receives care for a short period, generally less than 90 days; the other, made up primarily of elderly and disabled people, receives care on a continuing basis. For short-term recipients, nursing services make up the lion's share (63.0%) of home care received; the remaining services are divided between personal support (20.6%) and various other therapies (16.4%). In contrast, for continuing care recipients, personal support is the most prevalent service (59.2%), followed by nursing care (35.5%); therapeutic services are rarely necessary.[194]

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[192] "Provincial and Territorial Home Care Programs: A Synthesis for Canada," Health Canada, June 1999.

[193] Laporte A, Croxford R, Coyte PC: Access to home care services The role of socio-economic status. Presentation at the Canadian Health Economics Research Association Conference, Halifax, May 2002.

TABLE 8.1
PERCENTAGE OF ACUTE, LONG-TERM, AND OTHER CLIENTS, 1996-97
(JURISDICTIONS WHERE DATA ARE AVAILABLE)

Province/ Territory	Acute Care Clients	Long-Term Care Clients	Others	Total
B.C.	56.4	34.5	N/A	90.9
Alta.	41.0	52.0	7.0	100.0
Sask.	22.9	70.5	6.6	100.0
Que.	21.1	63.7	15.2	100.0
N.B.	53.3	46.6	N/A	99.9
P.E.I.	20.0	75.0	5.0	100.0
Y.T.	16.6	73.7	9.6	99.9
Canada	**33.0**	**58.0**	**8.7**	**99.7**

The Committee believes the model of home care delivery pioneered in New Brunswick should be highlighted.

8.3 The Extra-Mural Program in New Brunswick

Founded in 1981, under then Health Minister, now Senator, Brenda Robertson (a member of this Committee), the New Brunswick Extra-Mural Hospital (NBEMH) was Canada's first government-funded home-hospital program. It is often cited as a possible model for other jurisdictions. Designated as a Hospital Corporation under the New Brunswick Hospital Act, its services were eligible to be insured by the province. "The mission of the NBEMH was to provide a comprehensive range of coordinated healthcare services for individuals of all ages for the purpose of promoting, maintaining and/or restoring health within the context of their daily lives."[195]

In 1996, a major restructuring of the NBEMH took place. A change in legislation changed the status of the NBEMH from that of a Hospital Corporation to its current status as an Extra-Mural Program (EMP). Management of the existing service delivery units devolved to the eight Region Hospital Corporations (RHCs). The RHCs manage hospital facilities, community health care centres (four sites in the province), and the Extra-Mural Service Delivery Units located in their territory. While management of service delivery has been decentralized, overall direction, including development, standard setting, funding, and monitoring of the EMP is the responsibility of the Hospital Services Division of the New Brunswick Department of Health and Community Services.

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[194] Ibid.

[195] Brief to the Committee, p. 3.

Thirty service delivery sites provide for the delivery of EMP services to clients across the entire province. Staff includes clinical coordinators, liaison nurses, support staff, and field staff representing the disciplines of clinical nutrition, nursing, occupational therapy, physiotherapy, speech language pathology, social work, and respiratory therapy. All professional staff members are employees of the EMP who work in interdisciplinary teams. Support services such as homemaking and meals-on-wheels are contracted. Direct care staff provides the case-management function as well. Nursing services are available 24 hours a day, seven days a week, while all other disciplines deliver services Monday to Friday.

Clients of the program fall into one of four categories or groupings:

- ***Acute Care:*** The objective is to facilitate early discharge or prevent admissions to more costly facilities, including hospitals; to improve or restore function through the provision of assessment and intervention in clients' natural environments. Services include, but are not limited to, selective chemotherapy, oxygen therapy, diabetes management, IV therapy, wound care, intravenous hydration and medication administration, and post-operative rehabilitation.
- ***Continuing Care:*** the objective is to maintain and prevent further deterioration in health/function so that individuals can remain in their current environments for as long as possible. Services include, but are not limited to, oxygen therapy; medication assessment, management, and monitoring; seating and positioning; adaptive equipment aids/prescription; support for individuals on mechanical ventilation; and group therapy.
- ***Promotive/Preventive Care:*** The purpose is to provide information, advice, or any planned combination of educational and organizational supports to maintain or enhance health; to prevent the occurrence of injuries, illnesses, chronic conditions and their resulting disabilities.
- ***Palliative Care:*** the objective is to provide interventions that help alleviate pain and manage the symptoms of a terminal illness; to provide support and respite to individuals and their informal support networks so individuals may die at home or delay admission to a medical care facility for as long they so choose.

Assessment, treatment, education, and consultation are a component of each type of care. The services provided are intended to promote client independence for as long as possible. At its inception the budget for the EMP was $250,000. As shown in Table 8.2, in a province with a total population of just over 750,000 it has grown into a program with a budget around $40 million. It offers an example of how it is possible to phase in a comprehensive home care program over time.

8.3.1 Building on the New Brunswick example: direct referrals to home care

The Committee took particular note of the fact that the New Brunswick EMP enabled doctors to refer patients directly to the program. Cheryl Hansen, Provincial Director of the EMP, told the Committee that "between 50 to 60 per cent of the EMP total caseload is for acute care services or is the acute care replacement and substitution function of hospitals." In her brief to the Committee she further indicated that "approximately 55% of acute care clients are admitted directly from the community,"[196] without having been admitted to a hospital. The Committee highlights this aspect of the EMP in the hope that other jurisdictions will consider developing similar programs that offer the possibility of extending the range of services available to Canadians under the *Canada Health Act* in an effective and cost-efficient fashion.

[...] "approximately 55% of acute care clients are admitted directly from the community," without having been admitted to a hospital. The Committee highlights this aspect of the EMP in the hope that other jurisdictions will consider developing similar programs that offer the possibility of extending the range of services available to Canadians under the* Canada Health Act *in an effective and cost-efficient fashion.

TABLE 8.2
EXTRA-MURAL PROGRAM – ASSORTED DATA

	1996-97	1997-98	1998-99†	1999-00†	2000-01*‡
Staff (FTE)	527	590	592	608	668
Separations[3]	10,866	11,972	12,680	13,924	19,941
Nursing Visits[1, 3]	270,145	275,586	295,817	326,630	282,813
Rehab. Visits[2, 3]	34,107	64,080	93,459	87,946	78,609
Other Visits[3]	40,457	42,587	43,522	45,040	39,148
Total Visits	344,709	382,253	432,720	459,616	400,570
Gross Expenditures ($M)	$28.6	$31.7	$35.0	$37.2	$39.7
Average Cost / Visit[3]	$83	$83	$81	$81	$99
Average Cost / Separation[3]	$2,632	$2,662	$2,758	$2,674	$1,990

Source: New Brunswick Department of Health and Wellness, Annual Report 2000-2001.

Notes:

1. Includes occupational therapy, physiotherapy and speech language pathology visits.
2. Includes social work, clinical nutrition, and respiratory therapy visits .
3. For 1999-2000 fiscal year only, due to the implementation of a new EMP information system, statistics are estimated based on activity data collected from April to September 1999.

† Staffing and volume increases attributed to the Rehabilitation Services Plan

* Preliminary data

‡ Statistics may vary from previous years as EMP went live with a new information system in 2000-01 (EMP Information System). Collection of statistics is according to New Brunswick MIS guidelines in 2000-01.

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[196] Brief to the Committee, p. 3.

8.4 Organizing and Delivering Post-Acute Home Care

In this section and the two that follow, the Committee outlines its specific proposal for a national program to provide publicly funded insurance coverage for post-acute home care, that is, for people requiring treatment at home following an episode of hospitalization.[197] We describe mechanisms for the financing, delivery and organization of home care following hospitalization.

Although other types of home care services are also important contributors to good health, the Committee believes it is important to focus at this time on the financing, organizing, and delivery of post-acute home care. The Committee's objective is to stimulate the development of a new national program that provides public insurance coverage for services that are now delivered to Canadians in their own residences and are not therefore covered under the provisions of the *Canada Health Act*. Although we do not now propose a comprehensive home care program, the Committee is convinced that it is important to begin with what we believe to be a fiscally feasible expansion of the health care safety net in Canada.

...the Committee believes it is important to focus at this time on the financing, organizing, and delivery of post-acute home care.

8.4.1 Definition of post-acute home care

Post-acute home care refers to the provision of home care services to patients who have experienced an episode of hospital care. The first challenge to face in developing a national program for post-acute home care is in the identification and classification of home care following hospital care and linking relevant home care services to an initial episode of hospital care, whether in-patient care or same-day surgery.

...the Committee is convinced that it is important to begin now a fiscally feasible expansion of the health care safety net in Canada. We believe our proposed program meets the test of fiscal feasibility.

8.4.1.1 When does Post-Acute Home Care (PAHC) servicing start?

Fortunately, studies have explored the definition of post-acute home care (PAHC) in the context of health service restructuring.[198] Most experts have defined post-acute home care recipients as individuals who received their first home care visit within 30 days of their in-patient or same-day hospital discharge date. Initiation of home care beyond 30 days of discharge is unlikely to be directly related to previous hospitalization.[199] An interval shorter than 30 days might exclude episodes of home care that were related to the prior hospitalization but were postponed because of scheduling or other difficulties.

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[197] The Committee wishes to acknowledge the invaluable assistance of Dr. Peter Coyte in the preparation of its proposal for the development of a national publicly funded program for post-acute home care. Professor Coyte is Professor of Health Economics and CHSRF/CIHR Health Services Chair at the University of Toronto. He is also the Co-Director of the Home and Community Care Evaluation and Research Centre, and the President of Canadian Health Economics Research Association. Many of the specific recommendations were developed by Professor Coyte in a background paper prepared at the request of the Committee.

[198] Coyte PC, Young W: Regional variations in the use of home care services in Ontario, 1993/1995. *Canadian Medical Association Journal*, 161:4, 376-380, 1999; Coyte PC, Young W: *Reinvestment in and use of home care services*, Technical Report No. 97-05-TR, Institute for Clinical Evaluative Studies: Toronto, Ontario, November, 1997; Coyte PC, Young W, DeBoer D: *Home care report for the Health Services Restructuring Commission*. Report to the Health Services Restructuring Commission, Health Services Restructuring Commission: Toronto, 1997.

The Committee therefore proposes that post-acute home care recipients should be defined as individuals who received their first home care visit within 30 days of their in-patient or same-day hospital discharge date.

The Committee therefore proposes that post-acute home care recipients should be defined as individuals who received their first home care visit within 30 days of their in-patient or same-day hospital discharge date.

8.4.1.2 When does PAHC servicing end?

While there appears to be consensus in the literature on the definition of who should initially qualify as a PAHC recipient, the identification of those home care services that are relevant or attributable to the original hospitalization represents a greater challenge. The current ad hoc solution has usually been to impose an arbitrary date beyond which further in-home servicing may be presumed to be unrelated to the original reason(s) for hospitalization. In some instances this cut-off date has been one year after discharge;[200] in other cases it has been 60days. One rationale for use of the 60 day limit is that it is consistent with the short stay (or short term) classification of home care episodes; episodes of home care that extend beyond 60 days are then classified as long stay (or continuing care).

It is important to note, that over 50% of PAHC recipients are discharged from home care before 30 days of home care have elapsed, and almost 70% before 60 days; only 12.7% receive PAHC past six months. The Committee has decided to adopt a cut-off date of three months, that is a period inbetween 60 days and six months. Hence, somewhere in the range of 75-80% of PAHC recipients will have been discharged from home care before the three months have elapsed.

The Committee therefore recommends that:

An episode of PAHC should be defined as all home care services received between the first date of service provision following hospital discharge, if that date occurs within 30 days of discharge, and up to three months following hospital discharge.

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[199] Hollander M: *The costs, and cost-effectiveness of continuing care services in Canada.* Queen's-University of Ottawa Economic Projects Ottawa,1-113, 1994; Coyte and Young (1999); Coyte and Young (1997); Coyte, Young and DeBoer (1997); Kenney GM: How access to long-term care affects home health transfers. *Journal of Health Politics Policy and Law*, 83: 412-414, 1993.

[200] Coyte and Young (1999); Coyte and Young (1997); Coyte, Young and DeBoer (1997).

8.4.2 Organizational arrangements for PAHC

The national estimates of the total cost of the Committee's PAHC program will be derived below. The manner in which such funds are allocated and the mechanisms used to assign responsibility for the organization and delivery of such care are tremendously important. This section outlines mechanisms for the finance, organization and delivery of PAHC.

Control and responsibility for the organization and delivery of PAHC varies across Canada but is usually the responsibility of organizations that are distinct from hospitals. This has created parallel sets of entrenched interests, pitting organizations responsible for hospital care against those responsible for home care, and creating conflict that has foreclosed on or restricted opportunities for service integration, stifled innovation and put unnecessary limits on service cost-effectiveness.

Therefore the Committee believes that it would be a mistake to continue to fund those organizations charged with the distinct responsibility to negotiate, select, approve, and evaluate (internal or external) contractual arrangements with home care providers. The development (or perpetuation) of a separate program for PAHC that entails another set of vested interests would do little to ensure that funding follows the care recipient. The financing of PAHC should be first directed to hospitals, and the Committee recommends that:

Financing for post-acute home care should be first directed to hospitals.

There is an abundance of evidence to indicate that hospitals respond in predictable ways to financial incentives. The introduction of service-based reimbursement, whereby hospitals are reimbursed at a fixed rate for each type of service delivered (in keeping with the Committee's recommendations on hospital funding in Chapter Two), would provide incentives to shorten lengths of stay and to shift the hospital caseload toward day surgery and away from in-patient care.[201] Furthermore, given the relationship between PAHC and hospital care, the introduction of service-based reimbursement for hospitals would increase their demand for PAHC.[202]

Directing the funding for the provision of PAHC to hospitals will allow them to benefit from the potential cost-savings associated with shorter lengths of stay, thereby encouraging the uptake of home care and greater use of PAHC.

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[201] A variety of studies have explored the classification of linked episodes of hospital care and PAHC. Based on the work performed for the Health Services Restructuring Commission in Ontario, for example, each inpatient and same day surgery hospitalization could be assigned to one of twenty-five mutually exclusive and exhaustive Major Clinical Categories (MCCs) in the case of inpatient care, and one of six Day Procedure Groups (DPGs) in the case of same day surgery. [Coyte and Young (1999); Coyte and Young (1997); Coyte, Young and DeBoer (1997); Kenney (1993); Canadian Institute for Health Information: *Length of stay database by CMG*. Ottawa. Canadian Institute for Health Information, 1994. Canadian Institute for Health Information: *DPG booklet*. Ottawa. Canadian Institute for Health Information. 1996.]

[202] Kenney (1993); Kenney GM: Understanding the effects of PPS on Medicare home health use. *Inquiry*, 28: 129-139, 1991.

Directing funding for the provision of PAHC to hospitals will allow them to benefit from the potential cost-savings associated with shorter lengths of stay, thereby encouraging the uptake of home care and greater use of PAHC.[203] In contrast, if a separate organization were financed for the provision of in-home care, the potential cost-savings achieved through either shorter hospital stays or the use of day surgery would be much less likely to be captured, and hence, would not have a direct impact on decisions regarding service provision.

Consequently, the Committee believes that efficiency gains in the provision of both hospital care and PAHC are better advanced through the vertical integration and joint financing of these services, and recommends that:

> **In order to encourage innovation and service integration, and to enhance the efficient and effective provision of necessary health care irrespective of the setting in which such care is received, a service-based method of reimbursement for PAHC should be developed in conjunction with service-based arrangements for each episode of hospital care.**

Furthermore, in the Committee's view, PAHC programs should not be restricted only to nursing and therapy services. This could lead to distorted patterns of practice because PAHC recipients, like many patients using other forms of home care, utilise a full array of home care services. Limiting the scope of services covered under the program might encourage hospitals to substitute nursing services for other kinds of personal support services that would be more cost effective, raising, rather than lowering, the aggregate cost of care.

This point was reinforced by the experience of the New Brunswick Extra-Mural Program. In her brief to the Committee, Cheryl Hansen indicated that one of the lessons they learned was that:

> *The acute care substitute function of homecare requires a comprehensive team working collaboratively to meet the needs of the client and family. An essential component of acute care services is the provision of appropriate short term home support services e.g., homemaking.[…]The funding and provision of adequate short term support needs to be addressed in order for the replacement/ substitution function of homecare to occur in a fashion that ensures quality service for the client and family.*[204]

For these reasons the Committee believes that the reimbursement arrangements for the provision of home care following hospital care should be flexible in order to encourage innovation and efficiency and recommends that:

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[203] Kenney (1993).

[204] Brief to the Committee, June 17, 2002, p. 7.

The range of services, products and technologies (including prescription drugs) that may be used to facilitate the use of home care following hospital care not be restricted.

8.4.3 Who provides PAHC?

The Committee recognizes that the methods by which PAHC is organized and delivered is a separate question from how these services are funded, and that many different forms of service delivery are feasible. In some circumstances, hospitals may provide the services themselves; in others, hospitals may contract with not-for-profit or for-profit home care service providers; in yet other circumstances, hospitals may contract with third-party agencies that sub-contract with home care service providers.

In some circumstances, hospitals may provide the services themselves; in other situations hospitals may contract with not-for-profit or for-profit home care service providers, or in other circumstances hospitals may contract with third party agencies that sub-contract with home care service providers.

The organizational options for PAHC are many and offer a variety of potential benefits. First, the establishment of separate third party home care agencies may present some hospitals with an opportunity to pool resources and gain economies of scale in service provision, despite the potential to incur additional contracting and other administrative costs.

Second, hospitals may develop dedicated in-home service teams to deal with the particular community circumstances faced by care recipients.

Finally, hospitals may contract-out (or out-source) the provision of PAHC to home care service providers. This arrangement has a number of advantages. It can permit service specialization by providers familiar with circumstances in the community; it offers the prospect of service integration between hospital and PAHC; and it yields opportunities to take advantage of cost savings associated with improvements in patterns of care.

The Committee therefore recommends that:

Hospitals have the option to develop contractual relationships directly with home care service providers or with transfer agencies that may provide case management and service provision arrangements.

Regardless of the organizational arrangement selected, the providers of PAHC should receive service-based reimbursement.

Regardless of the organizational arrangement selected, the providers of PAHC should receive service-based reimbursement. As described in detail in Chapter 2, the amount of money a provider is paid under service-based funding depends on the acuity of the case being treated. Thus, service-based funding levels would be determined by clinical guidelines. This method ensures that the PAHC service providers receive a flat rate for their services to a specific patient, thereby encouraging service innovation and integration, and enhancing the efficient and effective allocation of health care services.

Reimbursing home care service providers with a fixed, predetermined payment offers a number of incentives. First, providers may retain residual income and therefore have the incentive to select the most efficient ways of delivering services. Second, to take advantage of economies of scale and scope, both vertical and horizontal service integration may occur. Such integrated organizations may be in a better position than other organizations to delegate tasks cost-effectively and improve the continuity of care. Third, to the extent to which payment exceeds the costs incurred in service provision, incentives exist for such organizations to compete for additional care recipients.[205]

However, there is a negative incentive given that this reimbursement method also tends to encourage the avoidance of care recipients with high service needs, i.e., "cherry-picking." Also, in the absence of a vigilant program of evaluation, organizations may be tempted to skimp on service provision, potentially leading to diminished quality of care. Consequently, the determination of an appropriate risk-adjusted service-based payment that closely reflects the service needs of PAHC recipients and the introduction of a systematic program of outcome performance, are policies that must be developed in concert with modified funding schemes to ensure cost-effective and uniformly accessible PAHC of high quality.

The Committee therefore recommends that:

Contracts formed with home care service providers should include, in addition to service-based reimbursement arrangements, mechanisms to monitor service quality, performance and outcome.

8.5 The Cost of a National Post-Acute Home Care Program

8.5.1 How to calculate the cost of a national PAHC program

As shown in Figure 8.3 (at the end of this chapter), there are wide interprovincial variations in per capita public home care expenditures in Canada, variations that persist even after adjusting for the age-sex composition of the underlying population. While the average per capita public funding for home care in fiscal year 2000 was $87.51, there was a four-fold variation in such expenditures, ranging from the highest in New Brunswick ($193.76) to the lowest in Prince Edward Island ($47.85) and Quebec ($51.89).[206] These variations are due, in part, to the extent to which the provincial publicly funded home care program is extensive (as it is in New Brunswick) or quite restricted (as it is in Prince Edward Island and Quebec).

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[205] Valdeck BC, Miller NA: The Medicare home health initiative. *Health Care Financing Review*, 16:1, 7 – 16, 1994; Phillips BR, Brown RS, Bishop CE, et al: Do preset per visit payments affect home health agency behaviour? *Health Care Financing Review*, 16:1, 91- 107, 1994.

[206] Health Canada: *Health expenditures in Canada by age and sex 1980-81 to 2000-01*. Health Policy and Communications Branch, Health Canada: Ottawa, August, 2001.

Nationally, public home care expenditures were $2,690.9 million in fiscal year 2000.[207] In order to identify the proportion associated with PAHC, the Committee used methods based on previous work in Ontario for the Health Services Restructuring Commission.[208] All home care recipients were identified for fiscal year 1997 and assigned to one of four mutually exclusive categories, as shown in Figure 8.4 (at the end of this chapter), based on their use of home care in relation to an episode of hospital care.

Home care recipients were first classified according to whether they had had an episode of hospital care, whether inpatient or same-day surgery, during fiscal year 1997.[209] If they had had an episode of hospital care, the pattern of home care provision within 30 days of discharge was analyzed. If the first home care visit following hospital discharge took place within thirty days, the pattern of use of home care services in the 30 days prior to hospitalization was analyzed. Accordingly, the four home care recipient categories were: no hospitalization; no PAHC; PAHC without prior home care; and PAHC with prior home care.

The use of home care services and the average cost of such services were analyzed for one year following either the first home care service date (for recipients who did not receive PAHC) or the first home care service date following hospital discharge (for recipients who received PAHC).

Two estimates are offered for the proportion of total home care costs attributable to PAHC. The first (high) estimate is based on the proportion of home care *recipients* that received PAHC, while the second (low) estimate is based on the proportion of *expenditures* attributable to such care. While 42.8% of home care recipients received PAHC services, only 26.5% of total home care expenditures were attributable to such care. The use of both estimates on which to base the cost of a national PAHC program recognizes the uncertainty associated with developing cost estimates for a program of this kind, given the absence of a health information system relating to the use of home care services.

8.5.2 What about hidden costs?

In addition to home care service costs, other costs associated with the provision of PAHC are hidden in other provincial spending categories. Drug costs are a major item that is hidden. For fiscal year 2001, the Ontario Drug Benefit (ODB) program expenditure attributable to home care recipients was estimated at $86.8 million.[210] While this amount probably underestimates provincial drug program costs associated with the provision of home care, it may be used to approximate the hidden costs associated with the provision of PAHC.[211]

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[207] *Ibid.*

[208] Coyte and Young (1999); Coyte and Young (1997); Coyte, Young and DeBoer (1997).

[209] See Figure 8.4.

[210] Peter Coyte, Personal Communication, Mr. Carl Marshall, Associate Director, Administration, Finance and Eligibility, Drug Programs Branch, Ontario Ministry of Health and Long -Term Care, 2002.

[211] Suppose the identified ODB program expenditures attributable to home care only represents the hidden costs incurred by those under sixty-five years of age during their home care episode. Under this assumption, estimates of

8.5.3 How much will a national PAHC program cost?

A calculation done for the Committee combined estimates of the hidden costs with those for the direct service costs and, converting to 2002 dollars, used the growth in home care funding in Ontario between fiscal years 2000 and 2002 of 11.9% and estimated the cost of providing post-acute home care for a one-year period following hospitalization. This yielded a total cost estimate for a national PAHC program of between $1,021.1 million and $1,511.8 million for fiscal year 2002.[212] Given that the Committee has recommended a period of three months' coverage, it is legitimate to fix the estimated cost of the program at approximately $1,100 million per year. The Committee recognizes that this estimate is probably somewhat high.

8.6 Paying for Post-Hospital Home Care

The Committee believes the cost of a national PAHC program should be shared equally between the provincial and federal governments. It therefore recommends that:

The federal government establish a new National Post-Acute Home Care Program, to be jointly financed with the provinces and territories on a 50:50 basis.

This brings the total cost (in fiscal year 2002 dollars) of a National PAHC Program to be borne by the federal government to approximately $550 million per year.

It is also necessary to ask, however, whether the person receiving the home care – the patient – should also contribute to the cost of this expansion of publicly insured health care services. There are two ways of looking at this question.

The first is that the need for this expanded service arises as a result of the individual's having been in hospital and that the service is therefore simply an extension of hospital care which, under Medicare, should be "free" to the patient and paid entirely out of public funds. Moreover, one advantage of implementing this option of providing first-dollar coverage is that, since the full cost of home care coverage will be paid by the PAHC program, there is no reason for patients to object to shorter hospital stays. That is, no disincentive is introduced to the transfer of patients from high-cost hospital care to less expensive non-hospital care. This increases the likelihood of realizing efficiency gains for the health care system as a whole.

The second approach is that since patients are, for the most part, paying currently for at least some aspects of this home care service, it is reasonable that patients

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the hidden costs associated with an episode of home care are $627.97 (in 2001 dollars). Since these costs are assumed to be uniform across all categories of home care recipients, they may be used to compute a "hidden cost" inflation factor for PAHC. This inflation factor may be defined as one plus the ratio of the hidden costs ($627.97) to the cost per PAHC recipient. The latter depends on the home care costs attributable to PAHC recipients divided by the number of such recipients (137,915 from Figure 4). Using figures from Ontario, in conjunction with the high estimate for PAHC costs, the hidden cost inflation factor is (1.1731), while this factor is (1.2796) when using the low estimate for PAHC costs.

[212] The low estimate was calculated as $2,690.9 million * 1.119 * 0.265 * 1.2796, while the high estimate was derived as $2,690.9 million * 1.119 * 0.428 * 1.1731.

continue to pay a small part of the cost, provided that the actual dollar amount paid by the patient is adjusted in proportion to his or her income. The amount paid by the individual patient should be small enough to meet the test of the Committee's second objective for publicly funded health care, namely, that no Canadian should suffer undue financial hardship as a result of having to pay health care bills.

One method that has been suggested for implementing this second approach involves treating insured services as taxable benefits. Using this model, at the end of each year, people who had received services under the PAHC program would be sent a statement from the provincial government indicating the total cost of the home care services obtained. This cost would then become a taxable benefit. Patients could be protected against undue financial hardship as a result of having to pay this increased tax by capping the maximum amount of additional income tax any individual would have to pay at 3% of the individual's income.

This second view holds also that any new public money spent for expanded health care services should benefit those Canadians who can least afford to pay for these services; those who can afford to make a financial contribution to the cost should do so. Only by adopting this approach to the expansion of the public health care system, this argument continues, can Canada afford to close the widening gaps in the health care safety net. Indeed, this is one of the reasons the Committee's proposal for an insurance program to protect Canadians against catastrophic drug costs includes an element of "patient pay."

Nevertheless, with respect to its proposed new PAHC program, the Committee, after considerable reflection, agrees with the first view. Although it is concerned about the precedent of first-dollar coverage for expanded publicly funded services, the Committee believes that the advantages in terms of encouraging efficiency – encouraging the transfer of patients from higher-cost hospital beds to lower-cost home care beds – and equity, outweigh the disadvantages. With respect to the expansion of public health insurance to include post-acute home care, the Committee therefore recommends that:

> **The PAHC program be treated as an extension of medically necessary coverage already provided under the *Canada Health Act,* and that therefore the full cost of the program should be borne by government (shared equally by the provincial/territorial and federal levels).**

Figure 8.1: Public Home Care Expenditures in Canada 1980-81 to 2000-01

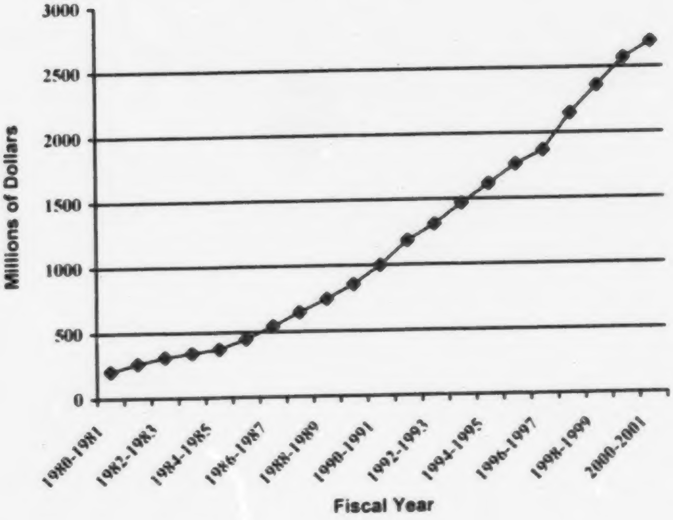


Figure 8.2: Private Home Care Expenditures in Canada 1980-81 to 2000-01

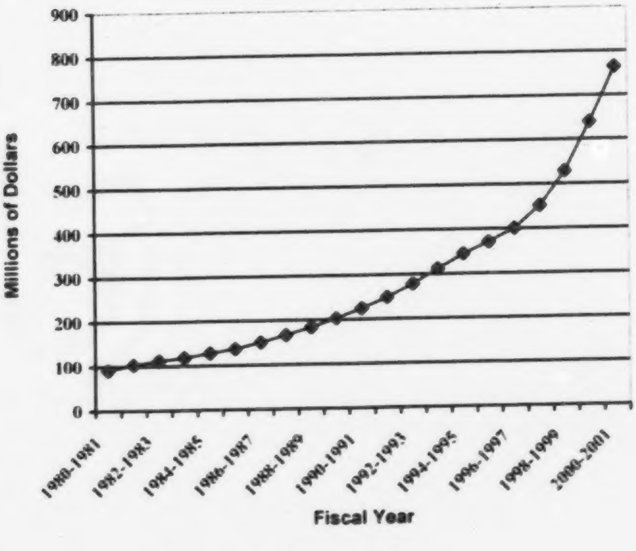


Figure 8.3: Per Capita Public Home Care Expenditures for Canadian Provinces and Territories, 2000-01

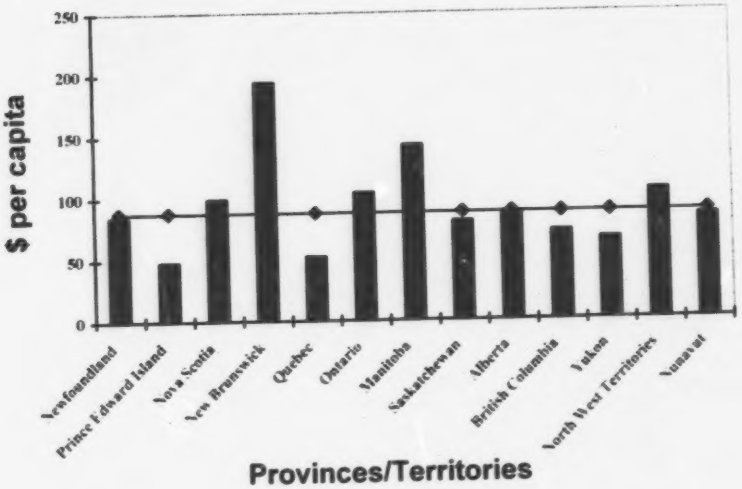
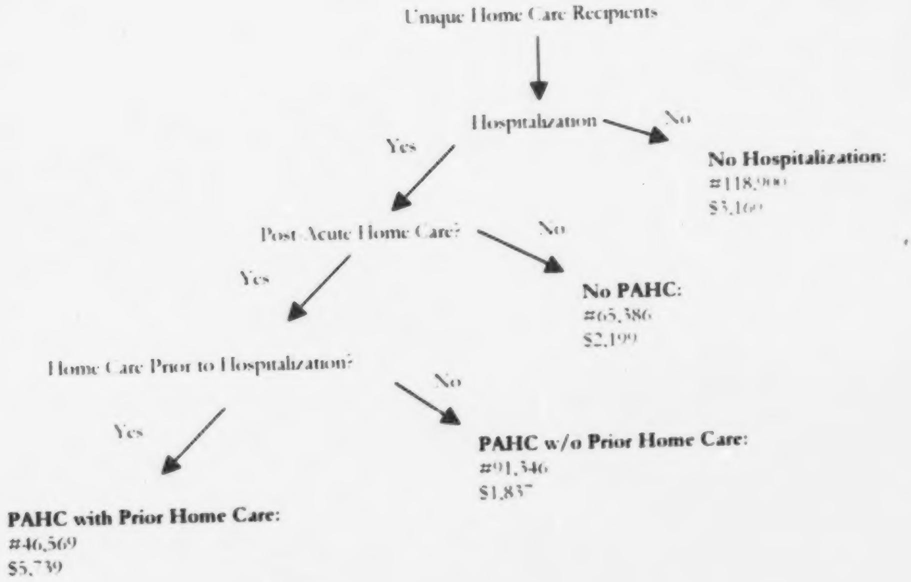


Figure 8.4: Home Care Recipients and Mean Expenditures (in 2002 Dollars)


Unique Home Care Recipients
Hospitalization
No
Yes
No Hospitalization:
#118,900
$3,160
Post-Acute Home Care?
No
Yes
No PAHC:
#65,386
$2,199
Home Care Prior to Hospitalization?
No
Yes
PAHC w/o Prior Home Care:
#91,346
$1,837
PAHC with Prior Home Care:
#46,569
$5,739

CHAPTER NINE

EXPANDING COVERAGE TO INCLUDE PALLIATIVE HOME CARE

Throughout the different phases of the hearings, the importance of palliative and end-of-life care was brought to the Committee's attention. Palliative care is a special kind of health care for individuals and families who are living with a life-threatening illness that has reached such an advanced stage that death is on the horizon.

The goal of palliative care is to provide the best possible quality of life for the terminally ill by ensuring their comfort and dignity and relieving pain and other symptoms. Palliative care is designed to meet not only the dying person's physical needs but also his or her psychological, social, cultural, emotional and spiritual needs and those of his or her family as well.

9.1 The Need for a National Palliative Home Care Program

Palliative care can be offered in a variety of places — at home, in hospitals, in long-term care facilities, and occasionally in hospices. As was reported by the Senate Subcommittee to Update *Of Life and Death* in June 2000, palliative care services in Canada are often fragmented and frequently nonexistent. Patients may not have access to palliative care services until very close to death and in many cases not at all. The report also indicated that palliative care in hospitals is usually paid for by a provincial health plan, which typically covers professional care and drugs, medical supplies, and equipment while the person remains in the hospital. In long-term care facilities, however, residents may be required to pay varying amounts for their care and supplies.

The Committee believes that there is a clear need to ensure that proper palliative care is universally available, and that it is provided in a manner that respects the wishes of the dying person and his or her loved ones.

The Committee believes that there is a clear need to ensure that proper palliative care is universally available, and that it is provided in a manner that respects the wishes of the dying person and his or her loved ones.

Different components of the health care system are involved in the many facets of palliative, end-of-life care. From a policy perspective, it is important that the federal and provincial/territorial governments work together to ensure that Canadians are well cared for and have choice in care at the end of their lives.

The Committee recognizes the importance of providing access to palliative care services for Canadians of all ages and across all relevant sectors of the health care system, hospitals, hospices, community services, as well as non-governmental organizations. It also recognizes that enabling universal access to palliative care services at all of these sites would require major changes that would be very hard to implement.

Recent studies have estimated that while over 80% of Canadians die in hospital, fully 80-90% of Canadians would prefer to die at home, close to their families, living as normally as possible. But the services necessary in the home are often not available. Where they do exist it is usually as result of initiatives taken at the community level or by local institutions and regional health authorities, rather than as a consequence of government policy intended to reach the whole Canadian population.

The Committee is convinced that it is essential for the federal government to make a substantial contribution to making palliative care services available to Canadians in their homes. However, it has proven impossible to obtain the data that would permit accurate estimates of the cost of a national palliative home care program. None of the experts or potential sources of accurate statistical information on palliative care with whom the Committee consulted had detailed costs on palliative home care. Nonetheless, the Committee believes the federal government should set aside the funds now to cover the initial costs of a program that should be developed in conjunction with the provinces and territories and paid for on a 50:50 cost-sharing basis. The Committee therefore recommends that:

> ***While the Committee is aware that there are important limits to what the federal government can achieve directly in this area, it is nonetheless convinced that it is essential for the federal government to make a substantial contribution to making palliative care services available to Canadians in their homes.***

> **The federal government agree to contribute $250 million per year towards a National Palliative Home Care Program to be designed with the provinces and territories and co-funded by them on a 50:50 basis.**

9.2 Financial Assistance to Caregivers Providing Palliative Care at Home

In addition to helping establish a national program to pay the costs of end-of-life care for Canadians who choose to die in their own homes, there are also other measures that the federal government should consider in order to alleviate the burden that now falls on the shoulders of thousands of informal caregivers. These are discussed in this section and the ones that follow.

> ***In addition to helping to establish a national program to pay the costs of end-of-life care for Canadians who choose to die in their own homes, there are also other measures that the federal government should consider in order to alleviate the burden that now falls on the shoulders of thousands of informal caregivers.***

Most of the costs of care in the home are currently assumed by the dying person's family. During Phase Two of its study, the Committee was told that, in general, the majority of informal caregivers are women who must often simultaneously manage responsibility both for aging parents and their own children while also holding down full-time paid work. This combination of responsibilities can not only lead to stress-related illness and loss of work time for the caregiver, but may also increase the risk of neglect and mistreatment of those receiving care.

In its 1999 report, *Caring about Caregiving: The Eldercare Responsibilities of Canadian Workers and the Impact on Employers*, the Conference Board of Canada found that 48% of those providing personal care in the home said it was very difficult to balance their personal and job responsibilities; 42% of them experienced a great deal of stress in trying to juggle their various roles; 57% felt that they did not have enough time for themselves; 53% cut back on sleep; and 44% had experienced minor health problems in the past six months.

These statistics, which apply to all caregivers at home and not just those delivering palliative care, illustrate how reliance on informal caregivers imposes costs on Canadians, while at the same time saving the health care system money. If care were not provided informally, in all likelihood greater costs would be incurred by hospitals and other providers.

In Volume Four, the Committee insisted on the importance of providing support to informal caregivers. It recognized that current tax provisions are inadequate to compensate informal caregivers for the time and resources they provide. The Committee highlighted the fact that the National Advisory Committee on Aging (NACA) had recommended that the Canada Pension Plan (CPP) and the Employment Insurance (EI) program be adjusted to accommodate individuals who leave the workforce temporarily to provide informal care.

With increased support in the form of a policy to provide caregivers with financial and information resources, dying Canadians would have access to quality care and would be able to choose where they wished to spend their final days. Increased assistance to caregivers would ensure that they have the knowledge, skills, income security, job protection and other supports they require to provide care to the dying while maintaining their own health and well-being throughout the dying and grieving process.

Many working Canadians are faced with stark choices as they try to balance the need to provide for their family with caring for a terminally ill family member. Minimizing the amount of lost income during this temporary but very difficult period would be an important first step toward improving the situation facing family caregivers of dying individuals.

Many working Canadians are faced with stark choices as they try to balance the need to provide for their family with caring for a terminally ill family member. Minimizing the amount of lost income during this temporary but very difficult period would be an important first step toward improving the situation facing family caregivers of dying individuals.

In Volume Four, the Committee referred to statistics from NACA that estimated that providing benefits through the EI system to persons leaving the workforce to care for an ailing relative would increase the overall cost of EI by about $670 million per year. This estimate was based on the total number of caregivers and a 10-week period of benefit payment. Using figures from Statistics Canada on the actual number of palliative care patients, and reducing slightly the period of eligibility for benefits, the Committee has determined that the overall cost to the EI system for providing benefits to informal caregivers who were caring for palliative care patients would be significantly less than NACA had calculated.

In 1999, 219,530 Canadians died. Not all, however, required palliative care. By eliminating accidental deaths and certain types of illness, the Committee has determined that approximately 160,000 Canadians can be expected to require palliative care in any given year. Using the average EI rate of $257 per week and a period of 6 weeks (instead of the 10-week period used by the National Council on Aging), providing EI benefits to individuals providing palliative care in the home would cost approximately $240 million per year. The Committee believes that up to six weeks of leave should be granted to employees who provide palliative care to a dying relative at home, and that the federal government should consider allowing employees who take advantage of this leave to be eligible to receive EI benefits. The Committee therefore recommends that:

> **The federal government examine the feasibility of allowing Employment Insurance benefits to be provided for a period of six weeks to employed Canadians who choose to take leave to provide palliative care services to a dying relative at home.**

9.3 Caregiver Tax Credit

The Employment Insurance system is not the only avenue that exists for providing support to caregivers. Tax credits are another option. The 1998 budget recognized that families caring for an ill loved one required government assistance, and implemented a tax credit that applies to individuals residing with, and providing in-home care for, an elderly parent or grandparent or an infirm, dependent relative. This credit reduces combined federal-provincial tax by up to $600.

The federal government also provides a medical expense tax credit. This credit allows Canadians to deduct the cost of certain medical devices, aids or equipment. A number of other tax credits also exist, including the disability tax credit and the attendant care expense deduction.

The Committee recommends that:

> **The federal government examine the feasibility of expanding the tax measures already available to people providing care to dying family members or to those who purchase such services on their behalf.**

9.4 Job Protection

Under the Constitution, the provinces have the primary responsibility for labour legislation, including job protection. However, there are areas that fall under federal jurisdiction, including the federal public service, military personnel, and individuals working in federal penitentiaries. People employed in these areas are governed by the Canada Labour Code and the Treasury Board assumes responsibility for employees of the federal government.

With regard to job protection, it would be possible for the federal government to take a leadership role in ensuring that people under its jurisdiction who take time off from work in order to care for a dying relative not endanger their employment status. The Committee therefore recommends that:

The federal government amend the Canada Labour Code to allow employee leave for family crisis situations, such as care of a dying family member, and that the federal government work with the provinces to encourage similar changes to provincial labour codes.

Furthermore, the federal government could take additional steps with regard to its own employees. The Committee recommends that:

The federal government take a leadership role as an employer and enact changes to Treasury Board legislation to ensure job protection for its own employees caring for a dying family member.

9.5 Concluding Remarks

The federal government can provide strong leadership and support for dying Canadians and their families, in particular by ensuring that Canadians who choose to die at home have access to the services that they need to do so with dignity. A new cost-shared palliative home care program would represent a major step toward making this possible.

As well, the additional measures recommended in this chapter would significantly improve the situation confronting family members who care for the dying at home. The Employment Insurance option would provide immediate financial assistance. Moreover, it would likely trigger job protection legislation in the provinces, as did extended maternity benefit legislation. The disadvantage of this option is that it is only available to insured workers. Tax credits, on the other hand, have the advantage of providing broader

The federal government is in a position to provide strong leadership and support for dying Canadians and their families, in particular by ensuring that Canadians who choose to die at home have access to the services that they need to do so with dignity.

coverage. However, such credits do not offer earnings replacement during the time of need, nor would they likely help to initiate job protection legislation.

Taken together, all the measures recommended in this chapter constitute a package that, if implemented, would mark real progress towards making quality end-of-life care for Canadians a reality.

Part V:
Expanding Capacity and Building Infrastructure

CHAPTER TEN

THE FEDERAL ROLE IN HEALTH CARE INFRASTRUCTURE

In Volume Five, the Committee presented its findings and general recommendations with respect to the role of the federal government in health care infrastructure.[213] These recommendations were based on the third of the roles the Committee spelled out in Volume Four for the federal government in health and health care, a role intended to "support health care infrastructure and health infostructure."[214]

In this chapter, the Committee provides more specific details on its recommendations relating to health care technology (Section 10.1), electronic health records (Section 10.2) and evaluation of quality, performance and outcomes (Section 10.3) – three areas of Canadian health care infrastructure which the Committee strongly feels must be given priority by the federal government.

The Committee strongly believes that health care technology, electronic health records and the evaluation of quality, performance and outcomes are three areas of Canadian health care infrastructure that must be given priority by the federal government.

The collection of patient information under a system of EHR and the related use of such information for the purpose of 1) clinical practice, 2) system management, 3) performance and outcome evaluation, and 4) health research, raise a number of important and complex issues with respect to the protection of personal health information; these are reviewed in Section 10.4

10.1 Health Care Technology

In Volume Five, the Committee noted that, despite the importance of health care technology in delivering timely and high-quality health services, the availability of many new technologies continues to be disproportionately low in Canada in comparison with other OECD countries. More specifically, Canada ranks 21st of 28 OECD countries in the availability of CT scanners, 19th of 22 in availability of lithotriptors, and 19th of 27 in availability of MRIs. Its only acceptable ranking is in the availability of radiation equipment, where it ranks 6th out of 17.

Data also show that this technology gap is widening. For example, the availability of MRIs in Canada worsened between 1986 and 1995 relative to other OECD countries, including Australia, France, the Netherlands and the United States.[215]

In addition, we noted in Volume Five that the aging of health care technology is also of concern. For example, information provided to the Committee indicated that between 30% and 63% of imaging technology currently used in Canada is outdated. Not only can the outdated nature of health care technology negatively affect the health of a patient, but it also raises concerns about the legal liability of health care providers.[216]

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[213] Volume Five, pp. 69-89.

[214] Volume Four, p. 9.

[215] Volume Five, pp. 69-70.

The Committee is concerned that the shortage of health care technology and the use of outdated equipment impede exact diagnosis and inhibit high-quality treatment. Moreover, we are concerned that the deficit in health care technology has been translated into limited access to needed care and lengthened waiting times. In our view, health care technologies are key to providing Canadians with timely and high-quality health care.

The Committee is concerned that the shortage of health care technology and the use of outdated equipment impede exact diagnosis and inhibit high-quality treatment. Moreover, we are concerned that the deficit in health care technology has translated into limited access to needed care and lengthened waiting times.

In September 2000, the federal government responded to the deficit in health care technology by establishing the Medical Equipment Fund (MEF). The MEF allocated $1 billion (transferred on a per capita basis over a two-year period) to the provinces and territories for the purchase of health care technology. The Committee has welcomed this injection of new federal funds. However, we raised a number of concerns in Volume Five about the MEF:

- First, some provinces have not applied for their share of this fund, possibly because the federal government requires matching grants that some of the poorer provinces have difficulty financing.
- Second, additional resources are required to operate the new equipment. Even if provinces can afford their share of the capital investment, they may have difficulty funding the additional ongoing operating costs.
- Third, the investment did not address the problem of old equipment that needs to be upgraded.
- Fourth, even with this new funding, Canada still does not rank at a level comparable to other OECD countries.
- And finally, there are apparently no mechanisms to ensure accountability on the part of the provinces/territories as to exactly where money targeted to purchasing new equipment is actually spent.

In July 2002, the Canadian Medical Association gave the Committee a report on the Medical Equipment Fund that addressed many of these concerns.[217] This background paper made the following observations:

- Because of the lack of a transparent accountability mechanism, it is very difficult to determine whether the MEF reached its intended destination.

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[216] Volume Five, p. 70.

[217] Canadian Medical Association, *Whither the Medical Equipment Fund?*, Background paper and technical notes, July 2002.

- Of the $1 billion allocated through the MEF, approximately 60% was used for new (incremental) spending on health care technology, while 40% was used to pay for already planned expenditures.
- The MEF resulted in a modest to significant improvement in the availability of health care technology in Canada compared to other OECD countries. For example, the gap in health care technology has been reduced significantly in terms of radiation equipment and MRIs since the introduction of the MEF, while a substantial gap remains with respect to CT scans, PET scans and lithotriptors.
- An estimated investment of $1.15 billion is still needed to bring Canada up to the 1997 level of the 7-OECD country average. Of this amount, $650 million is required for the purchase of new medical equipment and $500 million is required for additional operating costs. The latter amount is critical to ensure that the purchasing funds can in fact be used by all provinces/territories; otherwise, the investments may not be made due to the lack of fiscal capacity of some provinces/territories.

The overall estimate by the Canadian Medical Association is very conservative; the calculation rests on only selective technologies (CT scans, MRIs, lithotriptors, PET scans and linear accelerators). Moreover, the $1.15 billion investment in health care technology would bring Canada only to the level in 1997 of the other OECD countries for these five specific technologies.[218]

The Committee believes that additional funding is required for the purchase of health care technology. We also believe that the federal government should support the provinces and territories to purchase new medical equipment.

Other calculations by the Association of Canadian Academic Healthcare Organizations suggest that between $1.7 and $2.5 billion (or some $420 million per year over five years) is required by Academic Health Sciences Centres (AHSCs) for the purchase and operation of advanced medical equipment.

The findings in the papers by both the Canadian Medical Association and the Association of Canadian Academic Healthcare Organizations reinforce the observations and conclusions made by the Committee in Volume Five. Accordingly, we believe that additional funding is required for the purchase of health care technology. We also believe that the federal government should support the provinces and territories to purchase new medical equipment.

The Committee strongly feels that a better accountability mechanism is needed for targeted federal funds such as the Medical Equipment Fund.

It is the view of the Committee that the federal government should ensure that any new funding for health care technology be spent on *incremental* purchases of medical equipment and not to offset already planned expenditures. Moreover, we strongly feel that a better accountability mechanism is needed for targeted federal funds such as the MEF.

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[218] Association of Canadian Academic Healthcare Organizations, *Background Information in Support of a National Teaching Centre Health Infrastructure Fund*, Draft Submission to the Committee, 6 August 2002.

The Committee also noted in Volume Five that there is a need to perform more health care technology assessment (HTA) when considering the introduction of a new technology or the replacement of existing medical equipment.[219] HTA provides information on safety, clinical effectiveness and economic efficiency and also considers the social, legal and ethical implications of the use of health care technology. The Committee stressed that all levels of government invest less than $8 million in total in Canada on HTA, whereas the United Kingdom provides some $100 million to its national HTA body, the National Institute for Clinical Evidence. Accordingly, we recommended in Volume Five that the federal government provide additional funding to HTA agencies for the purpose of assessing new and existing health care technology.

Finally, the Committee believes that a significant portion of the funding for the purchase of health care technology should be provided to AHSCs that currently house a large proportion of advanced medical equipment. AHSCs are also well suited, given their physical and clinical infrastructure, to undertake state-of-the-art HTA activities. It is the view of the Committee that federal funding for health care technology should not be provided to privately owned and operated clinics since they do not perform teaching, assessment and research activities.

The Committee acknowledges the important role of AHSCs in introducing and assessing new health care technology. We also recognize that community hospitals require additional investment in new medical equipment as well. It is our view that the federal government must play a leading role in sustaining long-term investment in needed health care technology.

The Committee does not believe, however, that a program such as the MEF is the means by which such a goal should be achieved. We agree with witnesses that federal funding should be provided within a multi-year fiscal framework, responding to requests initiated by health care institutions themselves with review by a group of independent experts. This would, in our view, provide a more *effective* and *accountable* model of governance.

The Committee agrees with witnesses that federal funding should be provided within a multi-year fiscal framework, responding to requests initiated by health care institutions themselves with review by a group of independent experts.

More precisely, under this model, teaching hospitals, community hospitals and regional health authorities would be required to accompany a request with a sound rationale for additional resources. Each application would be evaluated on its own merits by an independent expert group that would report to the Minister of Health. Moreover, in order to ensure accountability, successful applicants would have to report on their disposition of the funds received. Therefore, the Committee recommends that:

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[219] Volume Five, pp. 72-75.

The federal government provide funding to hospitals for the express purpose of purchasing and assessing health care technology. The federal government should devote a total of $2.5 billion over a five-year period (or $500 million annually) to this initiative. Of this funding, $400 million should be allocated annually to Academic Health Sciences Centres, while $100 million should be provided annually to community hospitals. The community hospital funding should be cost-shared on a fifty-fifty basis with the provinces, while the Academic Health Sciences Centre funding should be 100% federal.

The institutions benefiting from this program be required to report on their use of such funding.

10.2 Electronic Health Records

The electronic health record (EHR) is based on an automated provider-based system within an electronic network that provides complete patients' health records including visits to physicians, hospital stays, prescription drugs, laboratory tests, and so on. In Volume Five, the Committee stressed that an EHR system is the first step in gathering health-related information that will allow for evidence-based decision making throughout the whole health care system. An EHR system also offers tremendous opportunities to integrate the various components of Canada's health care system that currently work in silos.[220]

The electronic health record (EHR) is based on an automated provider-based system within an electronic network that provides complete patients' health records including visits to physicians, hospital stays, prescription drugs, laboratory tests, and so on.

An important characteristic of an EHR system is that it can make patient data available to health care providers and institutions anywhere on a need-to-know basis by connecting interoperable databases that have adopted the required data and technical standards. Not only can an EHR system greatly improve quality and timeliness in health care delivery; it can also enhance health care system management, efficiency and accountability. Moreover, the data collected from an EHR system can provide very useful information for the purpose of health research.

The benefits of an EHR system are numerous:

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[220] Volume Five, pp. 78-80.

> *National, interoperable EHR solutions that bring comprehensive and portable information to health providers and their patients will empower Canadians and help to significantly improve the quality, safety, accessibility, timeliness and efficiency of services.*
>
> *Furthermore, EHR solutions will enable the creation, analysis and dissemination of the best possible evidence from across Canada and around the world as a basis for more informed decisions by patients, citizens and caregivers; by health professionals and providers; and by health managers and policymakers. They will also help maximize the return on ICT investments through alignment, and drive the development of common standards and interoperability.*[221]

All levels of government in Canada have recognized the importance of developing and deploying EHR systems. On September 11, 2000, the First Ministers agreed to work together to develop an interlinked EHR system over the next three years and to work collaboratively to develop common data standards to ensure compatibility and interoperability of provincial health information networks together with stringent protection of personal health information.

In support of the agreement reached by the First Ministers, the federal government committed $500 million in 2000-01 to a private not-for-profit corporation known as Canada Health Infoway Inc. (or *Infoway*). *Infoway* is not a federal agency or a Crown corporation, nor is it controlled by the federal government. The members of *Infoway* are the Deputy Ministers of Health of the provincial, territorial and federal governments *Infoway* is governed by a Board of Directors who are representatives of regions of Canada.[222] The Board also involves some independent directors.

In July 2002, *Infoway* forwarded a copy of its business plan to the Committee. As part of its business plan, *Infoway* intends to invest in projects that enhance patient care, build on the existing base of information management, ensure leverage of financial investments and align federal, provincial and territorial priorities in a sustained fashion in order to achieve a pan-Canadian EHR system.

The Committee recognizes that the cost of building a pan-Canadian, interoperable EHR system will greatly exceed the initial $500-million investment contributed by the federal government. Indeed, data from *Infoway* suggest that implementing a coordinated system of EHR throughout Canada will require $2.2 billion. Without coordination, that is if jurisdictions implement EHR in isolation from each other, the one-time costs of EHR

The Committee believes that both Canadians and their publicly funded health care system will benefit greatly if the system of electronic health records is national in scope. Indeed, a national EHR system is critical. To achieve this, the federal government must provide leadership and the necessary resources.

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[221] Linda Lizotte-MacPherson, President and CEO of *Infoway*, Letter to the Committee, 24 July 2002, p. 7.

[222] To date, Quebec has elected not to participate as a member and as such has not availed itself of its right to appoint a representative to *Infoway's* Board of Directors.

deployment would reach $3.8 billion. Accordingly, achieving the full deployment of an EHR system will require a significant alignment of effort on the part of all jurisdictions, a pooling of resources, partnerships with the private sector and new sources of funding.

Overall, the Committee is very enthusiastic about the work undertaken by *Infoway* in deploying a national system of EHR. We believe that both Canadians and their publicly funded health care system will benefit greatly if the system of electronic health records is national in scope. Indeed, a ***national*** EHR system is critical. It is our view that, to achieve this, the federal government must provide leadership and the necessary resources. Therefore, the Committee reiterates its recommendation from Volume Five that:

> **The federal government provide additional financial support to Canada Health Infoway Inc. so that *Infoway* develop, in collaboration with the provinces and territories, a national system of electronic health records.**

Furthermore, the Committee recommends that:

> **Additional federal funding to *Infoway* amount to $2 billion over a five-year period, or an annual allocation of $400 million.**

The issue of privacy, confidentiality and protection of personal health information in the context of an EHR system is perhaps the most sensitive one raised during the Committee's hearings on this question. We address this question in detail in Section 10.4 below. However, it is worth noting here that an EHR system has the potential to actually improve the present situation with respect to the privacy of patients' health information. Currently, the privacy of individual health records is not secure. Moreover, patients do not have effective access to their own records and, in fact, don't even know where those records are. The Committee is of the view that, in the absence of a common EHR, both privacy and health care are substantially at risk from the wide dispersal of fragments of a patient's record here and there in doctor's offices, hospitals, public health units, home care providers' files, nursing homes, etc.

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10.3 Evaluation of Quality, Performance and Outcomes

In Volume Five,[223] the Committee stated that long-term investment in information and communication technology, including an HER system, will allow the collection of more timely and better information on access to care, quality delivery, system performance and patients' outcomes. We also indicated that while governments must finance the HER system, they should not be responsible for assessing health data and evaluating quality and outcomes. We agreed with witnesses that, currently, collection and evaluation of health-related information is done by the same people who are responsible for paying for, and for providing, health services – that is, governments.

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[223] Volume Five, pp. 80-83.

Accordingly, we noted the fact that there is no independent assessment of outcomes and no external audit of the impact of various procedures on patients. This concern was also raised by various provincial commissions on health care. Based on the testimony and provincial reports, the Committee concluded that the role of the evaluator of the health care system must be separated from that of the insurer and provider in order to obtain an independent assessment of health care system performance and outcomes.

The Committee is convinced that the role of the evaluator of the health care system must be separated from that of the insurer and provider in order to obtain an independent assessment of health care system performance and outcomes.

As explained in great detail in Chapter One, the Committee believes that such independent evaluation should be performed at the national (not federal) level. This would allow for the pooling of expertise, thereby making the most effective use of the limited human resources currently available in Canada, and result in major economies of scale. This is why we have recommended in Chapter One the appointment of a National Health Care Commissioner charged with providing comments and recommendations on health care system performance, health status and health outcomes.

The Committee believes that such independent evaluation should be performed at the national (not federal) level by the National Health Care Commissioner recommended in Chapter One.

Moreover, the Committee believes that the work of the National Health Care Commissioner in evaluating health care system performance and outcomes should build on those national organizations that are currently devoted to the task of performing independent health care system evaluation.

One organization that the Committee believes strongly should collaborate in a national system of independent evaluation is the Canadian Institute for Health Information (CIHI). In our view, CIHI has a credible history in collecting standardized data and developing indicators for the health care system. Its work has been developed through a cooperative process involving various jurisdictions and multiple stakeholders.

It is the view of the Committee that CIHI has a credible history in developing indicators for the health care system.

In addition, CIHI already has extensive data holdings that serve to support monitoring of the health care system (in a variety of fields such as human resources, adverse events, waiting times, Case Mix Groups (CMGs), system performance, health status indicators, financial management, and so on). Furthermore, CIHI has already established credible mechanisms for reporting to the public.

Since its inception, CIHI has been providing the Canadian public, health care managers and policy makers with excellent information. However, its budget, which is currently set at $95 million over four years (2001-2005), falls short of the investment necessary to provide the information required to plan, manage and report on the impact on the health care system changes recommended by the Committee. Thus, we believe strongly that CIHI's budget must be augmented considerably.

Another national organization, the Canadian Council on Health Services Accreditation (CCHSA), has built a solid foundation on the basis of a voluntary accreditation process for health care institutions. The Committee learned that its strength derives from its primary focus on continuous quality improvement, a strength that should be preserved.

The Committee believes that, as part of a national system of evaluation, the mandate of CCHSA should be expanded to require regular accreditation, at regular intervals, for all sectors of health care (RHAs, public and private hospitals, primary health care settings, etc.). Accreditation should be based on well recognized national standards. If standards are not met and remediation is inadequate, then accreditation should not be given. The accreditation process would be supportive of a transparent accountability process.

Therefore, the Committee recommends that:

The federal government provide additional annual funding of $50 million to the Canadian Institute for Health Information. In addition, an annual investment of $10 million should be provided to the Canadian Council on Health Services Accreditation. This new federal investment will help establish a national system of evaluation of health care system performance and outcomes, and hence facilitate the work of the National Health Care Commissioner.

10.4 Protection of Personal Health Information

Electronic health records will likely affect the application of fair information principles in a number of ways. As compatible EHR systems are developed and implemented across the country, the traditional, bilateral relationship between patient and provider will be transformed into a more complex web of interactions between the patient and the health care system.

By their very nature, paper records are limited to discrete pieces of personal information that could feasibly be gathered in paper form, contained in a specific physical location, often collected by a single provider and accessible to that same provider in the context of one individual encounter at a time. This contrasts with EHRs, which can assemble a more complete, comprehensive and longitudinal record of a person's health information originating from multiple sources, captured in electronic form that is readily available and potentially accessible to multiple authorized users, in real-time, irrespective of location.

This transformation will inevitably affect how patients can meaningfully and practically exercise their right to protection of personal health information. Likewise, this transformation will affect how responsibility and accountability are coordinated and shared among the multiple users of that information.

For these reasons, advancements in health information technology, including the development and implementation of EHRs, are often perceived as threats to individual privacy. This is in part due to the potential for increased access by multiple users and the seeming lack of patient control over personal health information. This being said, however, health information technology also provides a real opportunity for increased protection of privacy, as compared to paper records, through more effective security safeguards to restrict access and enhanced tracking features to audit all transactions. It also offers the opportunity for increased, rather than diminished, personal access to and control of health information by patients. These potential advantages balance the potential threats of EHRs.

Health information technology provides a real opportunity for increased privacy protection through more effective security safeguards to restrict access and enhanced tracking features to audit all transactions.

A system of EHRs is planned as the first critical phase in the development of an eventual pan-Canadian health info-structure. The immediate and obvious benefits of EHRs in the context of primary health care include improved efficiency of the system through more effective management of patients' health records and integrated health services delivery. EHRs also promise improved health care by giving providers access to a more comprehensive understanding of their patients' health status as an essential aid for proper diagnosis, effective treatment and safe prescriptions, particularly in situations of emergency or out-of-province care.

EHRs also promise improved health care by giving providers access to a more comprehensive understanding of their patients' health status as an essential aid for proper diagnosis, effective treatment and safe prescriptions, particularly in situations of emergency or out-of-province care.

Moreover, the pan-Canadian health info-structure promises to empower patients with better health information as well. This will allow patients to make more informed choices about their own health, the health of others and the health care system. A health infostructure will allow health care managers to evaluate service providers better and will enhance accountability of the system. It will also provide researchers with the evidentiary bases needed to continue to improve health care and better understand the determinants of health.[224]

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[224] *Canada Health Infoway, Paths to Better Health*, Final Report of the Advisory Council on Health Infostructure. December 1999

Currently, there are three main privacy issues that must be addressed for EHRs to become a reality in Canada in the next five to seven years. These are:

1. The need for a more harmonized approach to privacy across all jurisdictions to allow for more consistent conditions for sharing personal health information among users and more consistent protection of personal health information for patients.

2. The need to develop robust and effective privacy safeguards, policies and procedures that can be implemented in a pragmatic, practical and cost-effective manner.

3. The need to build public confidence that personal health information will be protected in an electronic world.[225]

Currently, there is significant variation in privacy laws and data access policies across the country that poses a challenge for EHR systems that are dependent on inter-sectoral and inter-jurisdictional flows of personal health information. Differences in rules on how the scope of purpose is defined, the form of consent required, the conditions for substitute decision-making, the criteria for non-consensual access to personal health information, periods for retention of data and requirements for destruction, to name but a few, must be seriously addressed in order to enable the development of EHR systems.

In addition, existing oversight bodies in different sectors and jurisdictions have varying delegated legislative authority over some parts of an EHR system, but not others. Without some overarching coordination, this piecemeal approach will render very difficult, in practice, any system of review and oversight, process for approval, procedure for investigation and application of sanctions.

The Committee encourages ongoing federal/provincial/territorial efforts to develop a harmonized approach to protecting personal health information. In particular, the Committee recommends that:

The federal government work to achieve greater consistency and/or coordination across federal/provincial/territorial jurisdictions on the following key issues:

- **Need-to-know rules restricting access to authorized users based on their purposes;**

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[225] See Advisory Council on Health Infostructure, *Canada Health Infoway, Paths to Better Health*, Final Report, December 1999; Federal/Provincial/Territorial Advisory Committee on Health Infostructure, *Tactical Plan for a Pan-Canadian Health Infostructure*, 2001 Update; discussions of Regional Fora held by Canada Health Infoway Inc. summarized at http://www.canadahealthinfoway.ca/sub.php?lang=en&secLoc=frm).

- **Consent rules governing the form and criteria of consent in order to be valid;**

- **Conditions authorizing non-consensual access to personal health information in limited circumstances and for specific purposes;**

- **Rules governing the retention and destruction of personal health information;**

- **Mechanisms for ensuring proper oversight of cross-jurisdictional electronic health record systems.**

Another major challenge facing EHR development is the need to find ways of implementing compatible EHR systems in a manner that both protects people's right to privacy of personal health information and is feasible and workable in practice. While there may be ways of introducing the most stringent physical, technological and organizational safeguards possible, these may simply not work in practice or be cost-effective. Moreover, safeguards change significantly over time as technology and customary practice evolves, requiring constant updating and upgrading. Organizations must distinguish passing trends from well-tested and proven state-of-the-art measures and make realistic investment choices accordingly.

In an EHR environment, many players will be involved in the collection of personal health information for inclusion in the common record. There will be many authorized users that can potentially gain rightful access to the EHR, adding information and collectively participating in the development of the record. As control will be shared among various players and users, so too shall accountability be shared. A real challenge lies in coordinating and apportioning responsibilities so that patients' rights do not fall between the cracks. Despite the seemingly amorphous environment of an EHR system, patients must be able to direct their questions and concerns to an identifiable, responsible entity and exercise, in a meaningful way, their rights to access, correction and redress in the event of non-compliance.

Therefore, the Committee recommends that:

Canada Health Infoway Inc. and other key investors structure their investment criteria in such a way as to create incentives for developers of EHR systems to ensure practical and pragmatic privacy solutions for implementing the following:

- **State-of-the-art security safeguards for protecting personal health information and auditing transactions;**

- **Shared accountability among various custodians accessing and using EHRs;**

- **Coordination among custodians to give meaningful effect to patients' rights to access their EHR, rectify any inaccuracy and challenge non-compliance.**

In order to enable the development and implementation of EHRs, public trust and confidence are indispensable. There is currently little research on understanding the determinants of Canadians' attitudes about the use of their personal health information for different purposes. Such research is vital if EHRs are to be developed and implemented in a manner that takes into account these determinants and respects people's underlying concerns in specific contexts.

While the advantages of EHRs may be obvious to those who are in the business of developing them, these advantages must also be made obvious to individual Canadians. The promise of an eventual pan-Canadian health info-structure belongs to everyone. An informed and meaningful dialogue should occur, engaging all key stakeholders, including patient groups and consumer representatives. Providers will be better equipped to improve the quality of the care they deliver and integrate their services; policy-makers and managers will be better informed and able to ensure access to health care and accountability for actions throughout the system; researchers will be able to evaluate the effectiveness of health care products and services and better understand the determinants of Canadians' health; members of the public will be better empowered to make informed choices about their own health, their health care and about health-related policy. An open, transparent, and iterative public communication strategy would go a long way to bring home the many benefits of EHRs and the truly inclusive vision of an eventual pan-Canadian health info-structure. Therefore, the Committee recommends that:

Key stakeholders, including the federal, provincial and territorial Ministries of Health, Canada Health Infoway Inc., the Canadian Institute for Health Information and Canadian Institutes of Health Research, undertake the following:

- **Rigorous research into the determinants affecting Canadian attitudes regarding acceptable and unacceptable uses of their personal health information;**
- **Informed and meaningful dialogue with key stakeholders, including patient groups and consumer representatives;**
- **An open, transparent and iterative public communication strategy about the benefits of EHRs.**

CHAPTER ELEVEN

HEALTH CARE HUMAN RESOURCES

11.1 The Extent of Health Human Resource Shortages

Over the course of its hearings the Committee has heard overwhelming evidence of a persistent human resource shortage in all sectors of the health care system, affecting specialist physicians as well as family practitioners, registered nurses as well as licensed practical nurses, laboratory technologists as well as pharmacists. Addressing the supply of professionals in all health care disciplines and finding ways to increase their individual and collective productivity are two of the most pressing, yet complex, problems facing health care policy makers.

Addressing the shortage of professionals in all health care disciplines and finding ways to increase their individual and collective productivity are two of the most pressing, yet complex, problems facing health care policy makers.

Hardly a month goes by without the release of a new study or report that further documents the breadth and the gravity of the situation. A number of these that have appeared since the release of the Committee's last report tell a familiar story.

According to a new report issued by the Canadian Institute for Health Information (CIHI) in June 2002, physician supply in Canada peaked in 1993 and has suffered a 5% decline since then, bringing the ratio of physicians to population down to the level it was 15 years ago.[226] This report provided one more graphic illustration of the extent of the human resource shortage and its consequences, including fewer family doctors, fewer younger physicians and heavier workloads for doctors.

Two recent provincial documents on physician supply also lend further support to the view expressed by the Committee in its previous reports that the human resource question is one area where it is increasingly legitimate to speak in terms of a crisis confronting the system. The Quebec College of Physicians examined the numbers of doctors actually in practice, rather than relying on raw registration numbers, and found that the province would need more than 1,400 additional physicians to provide necessary services to the population.[227]

For its part, the Ontario Medical Association estimated that there was a further net loss of 110 physicians from that province between 1999-2000, bringing the total shortfall to an estimated 1,585 physicians. The report indicates that there are now over 100 underserviced communities in the province.[228]

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[226] Dr. Benjamin TB Chan, *From Perceived Surplus to Perceived Shortage: What Happened to Canada's Physician Workforce in the 1990s?*, Canadian Institute for Health Information, June 2002.

[227] *Medical Post*, June 4, 2002.

[228] Ontario Medical Association "Position paper on physician workforce policy and planning", April 2002.

At the same time, the Committee is concerned that all of the studies referred to above focus on the number of practising physicians, and do not address the problem of productivity. Clearly, improving physician productivity would reduce the numbers of additional physicians required in Canada.

For example, most surgeons say that they could increase their productivity if they were given more operating time, and greater access to short term beds for their patients, who could then complete their recovery at home.[229] This fact raises the following policy question: is it better to remove the existing roadblocks to improved surgeon productivity, or to produce more surgeons who will, like their predecessors, not be as productive as they could be or want to be because institutional constraints prevent them from increasing their productivity? Policy questions like these cannot be properly answered without a much better understanding of the current level of productivity of physicians and the barriers to increasing that productivity.

...the Committee is concerned that all of the studies referred to above focus on the number of practising physicians, and do not address the problem of productivity.

The Committee believes that it is essential that independent research organizations, not affiliated with the medical profession, undertake detailed studies of physician productivity and of the barriers that impede increases in productivity. Government, as the funder of the system, and those who actually provide health services must understand the factors that influence productivity in health care and how the productivity of the key personnel in the system can be improved.

The Committee believes that it is essential that independent research organizations not affiliated to the medical profession (such as CIHI or the CIHR), undertake detailed studies of physician productivity.

In other fields, the availability of, for example, information technology has increased the productivity of other professionals over the past 20 years. Surely better diagnostic equipment, more effective drugs, improved out-of-hospital treatments, combined with the improved health status of Canadians over the past 20 years should have made physicians more productive. But whether this has actually happened is not known. This is why the proposed research is needed.

The Committee believes that similar observations to those about physician productivity could also be made about other health care professionals. The Committee therefore recommends that:

> **Studies be done to determine how the productivity of health care professionals can be improved. These studies should be either undertaken or commissioned by the National Coordinating Committee on Health Human Resources that the Committee recommends be created.**

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[229] See Chapter 8 of this volume for the Committee's proposal for a post-hospital home care program

Three recently issued reports provide additional data on the extent of the shortage of nurses. CIHI reported in June 2002 that although there was a slight increase (1.2%) in the number of nurses employed in Canada between 1997 and 2001, it was not sufficient to keep pace with population growth. There are thus fewer nurses per capita in the country today than five years ago. The report also indicated that the nursing workforce is aging rapidly, with the average age of RNs employed in nursing going from 42.4 years in 1997 to 43.7 years in 2001.[230]

A study conducted for the Canadian Nurses Association that examined trends since 1966 noted "throughout the entire 35 years covered by the data series, the nursing workforce has seen the age composition shift to older age groups."[231] The CNA report also made projections with regard to nursing supply and demand for the next 10 to 15 years, concluding that "there will be a shortage of 78,000 RNs in 2011 and 113,000 RNs by 2016."[232]

The Final Report of the Canadian Nursing Advisory Committee, chaired by Mr. Michael Decter, was released in August 2002. It identified three barriers to a quality workplace for Canadian nurses,[233] namely:

- the need for an increased number of nurses;
- the need to improve the education and maximize the scope of practice of nurses;
- the need to improve working conditions of nurses.

Amongst its 51 recommendations designed to help eliminate these barriers, the Advisory Committee advocated that the number of new, first-year seats in schools of nursing for Registered Nurses be increased by 25% (roughly 1,100 new seats) in September 2004 and that this number be adjusted upward by a further 20% in each of the subsequent four years.

Still, not enough is known about the productivity of nurses and what could be done to improve it. For example, in its report, the Canadian Nursing Advisory Committee endorses the need for "provincial and federal resources […] to be directed toward the development of accurate and manageable strategies to measure and report on workload."[234] The Committee believes that the same type of productivity research that is proposed with respect to physicians is also needed in order to understand better how nurses spend their time at work, and what institutional barriers stand in the way of improved productivity. This is why the recommendation made above includes all health care professionals.

Although allied health professionals receive less public attention, the Committee has repeatedly drawn attention to the fact that the human resource shortage is not limited to doctors and nurses. For example, the Committee noted in previous Volumes that over 20 disciplines reported experiencing important shortages, ranging from physical and occupational therapists to radiography and medical laboratory technologists to public health inspectors.

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[230] Canadian Institute for Health Information, *Supply and Distribution of Registered Nurses in Canada, 2001 Report*, June 2002.

[231] Canadian Nurses Association, *Planning for the Future: Nursing Human Resource Projections*, June 2002, p. 20.

[232] *Ibid.*, p. 1.

[233] *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses*, Advisory Committee on Health Human Resources, 2002, p. 3.

[234] p. 36

Moreover, witnesses indicated that despite these shortages, enrolments in training programs are being cut. One example was medical laboratory technology in Alberta, where places in training schools had been cut from 40 to 20 students. Witnesses also referred to other disturbing figures, considering the ever-increasing demand for technical and professional employees attributable both to new technologies and to a growing population. For example, there has been a 42% decrease in the number of graduates from medical laboratory technology programs across the country since 1987, while diagnostic imaging produced 15% fewer graduates over the same period. The Canadian Society for Medical Laboratory Science has predicted a nation-wide shortage of general medical laboratory technologists within the next 5 to 15 years.

A further illustration was provided by the Canadian Pharmacists Association. It noted that a shortage of pharmacists is a problem in many countries including Canada, the United Kingdom and the United States. The under-supply of pharmacists translates into increased vacancies, longer delays in filling vacancies, increases in overtime hours, and market-based wage increases that exceed the cost of living. Another recent study suggests that well over 2,000 additional pharmacists could readily find work in Canada.

The decline in the number of graduates has also been compounded by what has been called "credential creep." This refers to the gradual increase in the educational levels required to gain employment in a particular field, said to be driven by increasing complexity of the work involved. Among the consequences of "credential creep" are that it takes longer to train new graduates, thereby exacerbating the existing shortages of all health care professionals.

Credential creep also has other consequences. On the one hand, it can lead to the transfer of some programs from community colleges to universities; on the other, it can lead to graduates seeking higher levels of compensation they believe are justified by the additional training they have undergone.

The Committee is concerned that these developments occur without sufficient independent study to verify that the changes in the level of qualification and remuneration are warranted. The Committee believes that a review of the length of time required to train various health care professionals is needed, as well as an examination of what is the most appropriate educational institution to provide the needed training.

11.2 Health Human Resources: The Need for a National Strategy

The Committee believes strongly that one of the major consequences of the growing world-wide shortage of health human resources is that Canada must develop a strategy to enable the country to become self-sufficient in health human resources.

The Committee believes strongly that one of the major consequences of the growing world-wide shortage of health human resources is that Canada must develop a strategy to enable the country to become self-sufficient in health human resources.

In the Committee's view, moving forward in this regard entails recognizing that such a strategy cannot be a "federal" one but must rather involve all stakeholders, bearing in mind that the training and education of health care professionals is a provincial responsibility. For Canada to attain the objective of self-sufficiency in health human resources, long-term cooperation and coordination among all stakeholders in the health care field are essential.

In the Committee's opinion, problems relating to interprovincial competition for graduates in health-related fields further highlight the necessity to develop a national health human resources strategy. Competition among different jurisdictions for scarce human resources, whether interprovincial or international, can lead to severe regional disparities in the ability to provide health care services.

The Committee believes that the federal government must play a much stronger role than it has to date in coordinating efforts to develop and implement a national health human resource strategy and to deal with shortages. Given that it is clear that there can be no "quick fix" to the crisis in health human resources, and that a wide range of interests and concerns must be considered in the search for long-term solutions, it seems to the Committee appropriate to recommend the establishment of an ongoing framework to deal with human resource issues. The Committee therefore recommended in Volume Five that:

The Committee believes that the federal government must play a much stronger role than it has to date in coordinating efforts to deal with health human resources shortages.

The federal government work with other concerned parties to create a permanent National Coordinating Committee for Health Human Resources, to be composed of representatives of key stakeholder groups and of the different levels of government. Its mandate would include:

- **disseminating up-to-date data on human resource needs;**
- **coordinating initiatives to ensure that adequate numbers of graduates are being trained to meet the goal of self-sufficiency in health human resources;**
- **sharing and promoting best practices with regard to strategies for retaining skilled health care professionals and coordinating efforts to repatriate Canadian health care professionals who have emigrated to other countries;**
- **recommending strategies for increasing the supply of health care professionals from under-represented groups, such as Canada's Aboriginal peoples, and in**

under-serviced regions, particularly the rural and remote areas of the country;

- **examining the possibilities for greater coordination of licensing and immigration requirements between the various levels of government.**

As noted earlier, the Committee also believes that the National Coordinating Committee on Health Human Resources should assume responsibility for studying how the productivity of health care professionals can be improved. It is also clear to the Committee that no single group of professionals, nor any single level of government, should predominate in the deliberations of the proposed National Coordinating Committee.

The Committee also recommends that the federal government undertake a number of specific initiatives designed to increase the supply of health care professionals, namely that:

The federal government:

- **Work with provincial governments to ensure that all medical schools and schools of nursing receive the funding increments required to permit necessary enrolment expansion;**
- **Put in place mechanisms by which direct federal funding could be provided to support expanded enrolment in medical and nursing education, and ensure the stability of funding for the training and education of allied health professionals;**
- **Review federal student loan programs available to health care professionals and make modifications to ensure that the impact of inevitable increases in tuition fees does not lead to denial of opportunity to students in lower socio-economic circumstances;**
- **Work with provincial governments to ensure that the relative wage levels paid to different categories of health professionals reflect the real level of education and training required of them.**

In previous volumes, the Committee had noted that there was a serious shortage of health care providers from Aboriginal backgrounds. In order to help to address this problem the Committee also recommended in Volume Five that:

The federal government work with the provinces and medical and nursing faculties to finance places for students

from Aboriginal backgrounds over and above those available to the general population.

Moreover, since all the measures described in the above recommendations take time to implement, various shorter-term measures are required to deal with the health human resources crisis. One such avenue involves the tax system. Short-term tax incentives were used in the late 1960s and early 1970s to attract university professors to Canada at a time when the country faced a severe shortage of qualified university faculty members. The Committee believes a similar approach should be considered at this time with respect to health care professionals. It therefore further recommends that:

In order to facilitate the return to Canada of Canadian health care professionals who are working abroad, the federal government should work with the provinces and professional associations to inform expatriate Canadian health professionals of emerging job opportunities in Canada, and explore the possibility of adopting short-term tax incentives for those prepared to return to Canada.

The following sections of this chapter contain additional observations related to the health human resources shortage in Canada, as well as a number of further recommendations to help alleviate it.

11.3 Increasing the Number of Physicians Trained in Canada

The recent CIHI report referred to above has made a new contribution to the discussion of physician supply in Canada by assigning weights to the various factors that have contributed to the decline in the ratio of physicians to population:

- about 25% of the decline can be attributed to longer postgraduate training for doctors, both because family doctors now require two years of postgraduate training instead of one before entering independent practice, and because a higher proportion of doctors are choosing to become specialists, which requires much longer training periods;
- 22% of the drop was attributable to fewer foreign doctors entering Canada;
- 17% was caused by increased physician retirement;
- to date, only 11% of the decline can be attributed to decreased enrolment in medical schools, but the full effect of the cuts of the 1990s will only be felt in coming years.

The author of the report, Dr. Ben Chan, notes that several key mistakes were made in policy design during the 1990s. In the first place, unintended consequences were not taken into account. For example, it was not fully appreciated that increasing the length of training (e.g., two rather than one year of postgraduate training for family physicians) permanently reduces the supply of physicians. Second, policies were not reviewed frequently enough, so the effects of a number of policies combined in unexpected ways to generate a larger shortage than was anticipated. Finally, measures that gave the system flexibility were eliminated; for example, students were forced to lock into career choices at very early stages in their undergraduate education without the benefit of practical experience or the possibility of changing their minds at a later date.[235]

The Committee remains convinced that the only long-term solution to the human resources crisis remains the development of a national strategy that focuses on training enough physicians and other health professionals in Canada to meet the country's needs, as well as on increasing physician productivity. A recent estimate provided to the Committee by Dr. Abraham Fuks, President of the Association of Canadian Medical Colleges (ACMC), indicated that simply to maintain the current physician to population ratio, 2,500 students would have to enter medical school by 2005, an increase of 640 students from the 2001 first-year enrolment of 1,860.[236]

The Committee remains convinced that the only long-term solution to the human resources crisis remains the development of a national strategy that focuses on training enough physicians and other health professionals in Canada to meet the country's needs, as well as on increasing physician productivity.

In Volume Five, the Committee recommended that the federal government provide ongoing financial assistance to the provinces to increase enrolments in Canadian medical schools. According to the ACMC, the cost per place in a Canadian medical school is currently estimated at $260,000 over a four-year period. An additional 640 students would therefore cost approximately $160 million per year once the new levels of enrolment were attained.[237] The Committee believes that this would be money well spent, and therefore recommends that:

The federal government contribute $160 million per year, starting immediately, so that Canadian medical colleges can enrol 2,500 first-year students by 2005.

Moreover, it is important to bear in mind Dr. Chan's conclusion that it is necessary to review regularly the levels of enrolment to ensure that they remain in accord with evolving circumstances. Dr. Fuks estimated that in order to offset current physician shortages (rather than merely maintaining the current physician to population ratio) it would be necessary to increase enrolments further to 3,000 first-year students by 2009. It is important to note, however, that such forecasts do not take into account the impact of potential improvements in productivity. The Committee believes it necessary to keep a careful watch on the situation, and recommends that:

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[235] Dr. Ben Chan, "How Canada can better manage its MD supply," *Medical Post*, June 25, 2002.

[236] Dr. Abraham Fuks, Brief to the Committee, July 23, 2002.

[237] The cost per student, per year is one quarter of the total of $260,000, that is $65,000. However, once there are the desired number of new students enrolled in each year of the four-year medical degree program, this $65,000 per student per year must be multiplied by four, so that the total cost of the new *places* is $260,000 per year.

The proposed National Coordinating Committee for Health Human Resources be charged with monitoring the levels of enrolment in Canadian medical schools and make recommendations to the federal government on whether these are appropriate.

Clearly, however, it will take time to raise the levels of enrolment, and it will be even longer before these increases translate into greater numbers of doctors in the field. In the short term, then, measures should also be taken to relieve some of the pressure. The Committee has already reiterated its recommendation from Volume Five that the federal government explore the possibility of adopting short-term tax incentives in order to repatriate health care professionals working abroad.

There are also a number of highly skilled and well-trained Canadians who are completing their basic medical education outside Canada, notably in Australia, Ireland and the UK. Dr. Fuks told the Committee that many of these students, who are receiving their training in high-quality medical faculties, are eager to return to Canada. The Committee believes that there should, therefore, be a robust policy of recruitment for such expatriate Canadians to return to Canada for post-graduate training and practice in this country.

In order to accommodate these returning students, as well as the international medical graduates discussed below, it will also be necessary to increase the number of post-graduate residency positions. Based on figures provided by the Association of Canadian Medical Colleges,[238] the Committee therefore recommends that:

The federal government should contribute financially to increasing the number of post-graduate residency positions in medicine to a ratio of 120 per 100 graduates of Canadian medical schools.

As the Committee noted in Volume Five, this will also allow Canadian physicians who are already in practice greater opportunity to re-enter postgraduate training and pursue additional qualifications.

11.4 Integrating International Medical Graduates

Another measure specific to dealing with the shortage of physicians is the development of a national plan to make better use of international medical graduates (IMGs) already here. In the past, Canada has been able to rely on recruitment from abroad to fill some of the gaps. For example, over 50% of doctors practising in Saskatchewan are international medical graduates who have been trained elsewhere and recruited to Saskatchewan later in their careers. However, other countries now face many of the same shortages that confront our system. There does not seem to make much sense for all developed countries to poach endlessly each other's highly trained health care professionals.

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[238] Dr. Fuks, *op. cit.*

Most experts estimate that there are currently at least 2,000 international medical graduates in Canada who are not licensed to work as physicians.[239] There is no common program for issuing credentials to IMGs, and each province has a limited program for admitting IMGs to residency programs. For example, Ontario reserves 40 spots for IMG training, but despite 1,000 applications last year only 25 were admitted.

There are some signs of progress, however. In April 2001, Manitoba launched the first permanent program in Canada to assist IMGs to obtain medical licences. It relies on a three-stage Clinicians Assessment and Professional Enhancement (CAPE) process, an evaluation tool developed by the University of Manitoba's faculty of medicine, to assess the medical knowledge and clinical skill of foreign-trained doctors. The CAPE program has proved so successful that the College of Physicians and Surgeons of Nova Scotia refers IMG applicants who do not have licensed North American training or clinical practice experience to the Manitoba program for assessment.[240]

Members of the Association of Canadian Medical Colleges recently concluded that there is a pressing need for a national strategy, incorporating national standards, to assist in integrating IMGs into the Canadian medical workforce. They proposed that there be a common evaluation program that would allow IMGs to be classified in one of four categories: their education and training is equivalent and they should be licensed practise in Canada; they need some extra training; their medical education is equivalent but they need to do postgraduate training here; or neither their education nor training is adequate and they have to begin again at a medical school in Canada.

The Committee therefore recommends that:

The federal government work with the provinces to establish national standards for the evaluation of international medical graduates, and provide ongoing funding to implement an accelerated program for the licensing of qualified IMGs and their full integration into the Canadian health care delivery system.

11.5 Alleviating the Shortage of Nurses

As noted earlier in this chapter, a study conducted for the Canadian Nurses Association indicated that the country would be short 78,000 RNs in 2011 and that this shortfall could reach 113,000 by 2016. The study reached these conclusions despite using what it calls relatively optimistic assumptions with regard to the number of nursing graduates that can be anticipated in the coming five years. The report estimates that "the output from Canada's nursing schools is expected to grow from 4,599 graduates in the year 2000 to more than 9,000 per annum by the year 2007."[241] (See Table 11.1, below).

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[239] *Medical Post*, June 11, 2002.

[240] Pamela Clarke, "The Foreign Question," *Medical Post*, May 28, 2002.

[241] CNA, *op. cit.*, p. 1.

TABLE 11.1
NUMBER OF NURSING GRADUATES, 1999-2008*

Year	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Canada	5,221	4,599	5,499	6,782	7,578	7,678	7,834	8,829	9,182	9,382

Source: Projections by Eva Ryten for the Canadian Nurses Association, June, 2002.
* 1999-2001, actual data; 2002-208, projections

But even with almost doubling the number of graduates, and an expected influx of 1,200 nurses trained abroad every year from 2002 onwards, the study categorically affirmed that it will not be possible to meet the anticipated demand for nursing services. Nor is there a sufficiently large pool of trained nurses who are not currently employed in nursing who could be enticed back into the profession in order to help deal with the shortfall. In fact, the report points out that:

> *It is particularly relevant to note that in both 2000 and 2001, there were fewer than 3,000 RNs who were not working as nurses but looking for jobs in nursing. This is a tiny number compared with the total stock of RNs in the country.*[242]

Nonetheless, the Committee believes that everything possible should be done to entice those qualified nurses who have left the profession to return to active nursing. This is all the more important since, even if it were deemed advisable to substitute licensed practical nurses (LPNs) for RNs, the report notes that there are not enough qualified LPNs to make up the shortfall either.

> *For licensed practical nurses to meet a significant portion of nursing service requirements that cannot be met by RNs due to the nursing shortage, the LPN complement would have to be growing at an extremely rapid rate. But, in fact, the number of LPNs has been stagnant or decreasing for nearly 20 years. In 1983, there were 83,539 LPNs in Canada. By 1999, this number was down to 66,100.*[243]

At the same time, Ms. Kelly Kay of the Canadian Practical Nurses Association told the Committee that:

> *In most jurisdictions, licensed practical nurses are in short supply. However, there are still situations such as in the province of Ontario where 1,400 registered practical nurses reported on their last registration data form that they were seeking employment in nursing.*[244]

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[242] *Ibid.*, p. 13.
[243] *Ibid.*, p. 74.
[244] 61:25

Although in 1997 it appeared that the trend was towards a decline in the number of applications to nursing schools, this no longer seems to be true. Ms. Ginette Lemire-Rodger, outgoing president of the CAN, explained to the Committee that:

> *In Canada, this year alone, thousands of well-qualified students have been turned away. The universities reject them because there are only 70 places for every 800 applications across the country. There is no lack of young people and not-so-young people wanting to take up nursing, but the governments are not funding the seats in the universities.*[245]

Clearly, then, everything points to the need to increase the number of nursing graduates in fairly dramatic fashion. The committee noted in Volume Five that Human Resources Development Canada (HRDC) has undertaken a major sector study in order to make recommendations with regard to the supply of nurses. However, as Michael Decter remarked to the Committee:

Clearly, then, everything points to the need to increase the number of nursing graduates in fairly dramatic fashion.

> *I know the Government of Canada through HRDC is funding two large studies. To paraphrase David Sackett, you do not need a double blind, random clinical trial to apply common sense. Common sense would say we need more nurses in this country and we need them urgently.*[246]

In calculating how many new places should be allotted, the CNA report cautions that in the long run it is important to avoid

> *periods of either very sharp increases or decreases in output over short spaces of time. Doing this repeatedly over long periods of time leads to a roller coaster of surpluses and shortages in supply. Ideally, levels of output would increase gradually each year in line with increased needs.*[247]

Had there not been a serious underfunding of nursing positions during the nineties, the CNA estimates that the number of graduates needed would still have been of the order of 10,000 per annum. The CNA report explained that this is because "even if the crisis of the 90s had never occurred, Canada would be facing nursing shortages in both 2011 and 2016, albeit of a smaller magnitude, because of the impending retirement of the larger graduating cohorts who are being replaced by smaller ones."[248] Taking the consequences of the erroneous decisions of the nineties into account, the CNA felt it prudent to recommend that nursing programs be expanded in order to attain an annual output of 12,000 graduates.

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[245] 61:16

[246] 52:8

[247] CNA, *op. cit.*, p. 76.

[248] *Ibid.*, p. 73.

The Committee endorses this estimate. Table 11.1 gives the projections contained in the report for current and projected provincial output of graduates until 2008. The Committee recommends that:

> **The federal government phase in funding over the next five years so that by 2008 there are 12,000 graduates from nursing programs across the country, and that the federal government continue to provide full additional funding to the provinces for all nursing school places over and above 10,000, for as long as is necessary to eliminate the shortage of nurses in the country.**

Using the figures given in Table 11.1 that indicate the anticipated levels of nursing graduates, this means that by 2008 it will be necessary to graduate an additional 2,618 nurses. The numbers could be increased as follows to build towards this figure:

TABLE 11.2

	2004	2005	2006	2007	2008
Current anticipated number of graduates	7,678	7,834	8,829	9,182	9,382
Projected number of graduates given additional federal funding	8,000	9,000	10,000	11,000	12,000

The Committee was told by the CNA that each additional nursing position in Ontario cost $7,700 per year. Based on a four-year program, this translates into approximately $30,000 to train each new nurse. Extending this estimate to all nursing places across the country, it would cost approximately $80 million per year to bring the number of nursing graduates to the 12,000 level recommended by the CNA.[249] To be sure that sufficient funds are available, and in light of the seriousness of the nursing shortage, the Committee believes that it would be prudent to set aside a further $10 million in the hope that more nurses could graduate even sooner. The Committee therefore recommends that:

> **The federal government commit $90 million per year from the additional revenue the Committee recommends that it raise in order to enable Canadian nursing schools to graduate 12,000 nurses by 2008.**

11.6 Allied Health Professionals

The Committee was not able to obtain sufficient data to work out a detailed proposal with regard to the precise numbers of new graduates that would be needed to respond to the shortages of allied health professionals discussed earlier in this chapter. Nonetheless, the Committee believes that it is essential for the federal government to commit funds to addressing these pressing needs. The Committee therefore recommends that:

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[249] This calculation was done on the same basis as for the medical students (i.e. 2,618. x $30,000)

> **The federal government commit $40 million per year from the new revenues that the Committee has recommended it raise in order to assist the provinces in raising the number of allied health professionals who graduate each year.**
>
> **The exact allocation of these funds be determined by the proposed National Coordinating Committee for Health Human Resources.**

11.7 Funding Post-Graduate Training

The cost of training new health care professionals does not end the moment they graduate from university or college. There are additional costs that are borne in large part by academic health sciences centres, not only for physicians but for the full range of health care professionals. The Association of Canadian Academic Healthcare Organizations (ACAHO) has estimated the additional costs associated with increases in health care training positions for all the health care professions to be in the range of $300 – $550 million over the course of their training cycle (or between $60 and $110 million per year). These costs include funding for instructors, space, overhead and supplies. The Committee therefore recommends that:

> **The federal government devote $75 million per year of the new money the Committee recommends be raised to assisting Academic Health Sciences Centres to pay the costs associated with expanding the number of training slots for the full range of health care professionals.**

11.8 Health Human Resources: Scope of Practice Rules Review

The final area of the Committee's human resource recommendations involves the need for a thorough independent review of the scope of practice rules for the various health care professions. This review needs to focus on removing the barriers to fruitful collaboration that now exist among health care professionals and that prevent some health care professionals (e.g., nurse practitioners) from using the full set of skills for which they have been trained.

The final area of the Committee's human resource recommendations involves the need for a thorough independent review of the scope of practice rules for the various health care professions.

The importance of dealing with this problem on an urgent basis was clearly stated by Dr. Duncan Sinclair, the Chair of the Ontario Health Service Restructuring Commission, in his testimony to the Committee:

> *Having a doctor do work that a nurse practitioner or nurse could do is like calling an electrician to change a light bulb or a licensed mechanic out of the garage to fill your tank and check the oil and tire pressure – would they do a good job? They would do an excellent job! But would it be a good use of their time, training and expertise? It would not! It would constitute an expensive and inefficient use of scarce resources, both of money and the expertise of very talented people.*[250]

The Committee believes that such expensive and inefficient use of scarce human resources needs to cease *now*. As noted in Chapter Four on Primary Health Care Reform, the synthesis report of the Health Transition Fund's primary care projects concluded with regard to nurse practitioners that:

> *A federal/provincial/territorial initiative should develop national standards for terminology and scope of practice. It should include legislative requirements that support an expanded role for nurses and nurse practitioners.*[251]

The Committee therefore recommends that:

> **An independent review of scope of practice rules and other regulations affecting what individual health professionals can and cannot do be undertaken for the purpose of developing proposals that would enable the skills and competencies of diverse health care professionals to be utilized to the fullest and enable health care services to be delivered by the most appropriately qualified professionals.**

11.9 Committee Commentary

The Committee acknowledges that there needs to be an increase in the number of people employed in each of the health care professions, and our recommendations are designed to address this problem.

But the Committee is also very concerned about the overall costs that this increase in human resource supply will entail for the system as a whole. The Committee is keenly aware, for example, that physicians are the major cost-drivers in the system.[252] Since increasing the supply of physicians does not decrease the average cost that each physician imposes on the system, as the number of practising physicians increases the only way in which the system could remain fiscally sustainable is for significant productivity improvements also to occur.

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[250] See Volume Four of the Committee's study, *Issues and Options*, p. 110-11.

[251] Ann L. Mable and John Marriott, *Health Transition Fund Synthesis Series – Primary Health Care*, June 2002, p. 29.

[252] There is also evidence to suggest that Canadian physicians are well remunerated compared to physicians in other countries. OECD data indicates that the ratio of average physician income to average employee compensation in Canada was 3.2. Only ratios in the United States (5.5) and Germany (3.4) were higher than Canada's, while the ratio

The Committee therefore feels that it is necessary for the increase in the numbers of educational positions to be accompanied by detailed studies of how to improve the productivity of each of the health care professions. If these studies are not done, and if productivity is not substantially improved, the Committee is concerned that this could lead to an unsustainable escalation of overall health care costs.

The Committee therefore feels that it is necessary for the increase in the numbers of educational positions to be accompanied by detailed studies of how to improve the productivity of each of the health care professions.

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was much lower in a number of other countries such as Australia (2.1), France (1.9) and the UK (1.4). See, Reinhardt, Uwe E., Peter S. Hussey and Gerard F. Anderson, "Cross-National Comparisons of Health Systems Using OECD Data, 1999" in *Health Affairs*, May-June, 202, p. 175.

CHAPTER TWELVE

NURTURING EXCELLENCE IN CANADIAN HEALTH RESEARCH[253]

Health research is about creating and applying new knowledge with respect to health and health care. Health research encompasses a full spectrum of activities that range from biomedical research, to clinical research, to health services research, and to population health research:

- **Biomedical research** pertains to biological organisms, organs, and organ systems. For example, this type of research would use animal or human tissues or cell culture to understand how the body controls the production of blood cells in the bone marrow, how those controls break down in leukemia, and how normal controls might be reinstated by treatment with drugs.
- **Clinical research** relates to studies involving human participants, healthy or ill. An example would include clinical trials on humans to test the toxicity and effectiveness of a possible new treatment for leukemia that has shown promising results in basic biomedical research, and then to compare the new drug with other drugs in terms of their net benefit to patients.
- **Health services research** embraces health care delivery, administration, organization and financing. An example might be research into the mechanisms for handling patients with leukemia, from the means for diagnosis, through their treatment in hospital, on an out-patient basis, or at home, to their long-term follow-up through hospital or community care.
- **Population health research** focuses on the broad factors that influence health status (socio-economic conditions, gender, culture, literacy, etc.). An example might be a study using large databases of personal health information gained from a number of sources to learn whether the incidence of leukemia is associated with environmental or other factors.

Health research is the source of new knowledge about human health, how to maintain optimal health, how to prevent, diagnose and treat disease, and how to manage our health care system. Health research leads to the development of new or improved drug therapy, treatment, medical equipment and devices, and new ways of organizing and delivering health care. Health research also contributes to a better understanding of the complex interplay of the social, economic, environmental, biological and genetic determinants that affect our health and our susceptibility to disease.

The Committee was told that health research fosters the creation of knowledge-based employment, which in turn contributes to reversing the brain drain observed in the country. Overall, witnesses stressed that health research improves the personal and economic health of Canadians and enhances our international competitiveness:

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[253] This chapter is an updated version of Chapter Five included in Volume Five, pp. 91-125.

> *Health research provides enormous economic, social and health care rewards to society. The jobs that are created by these investments are high-quality, well-paying, knowledge-based positions that generate worldwide recognition for Canadians. These investments also support the rejuvenation of academic institutions across the country. They help train new health professionals in the latest technologies and techniques and they provide important support for the health care delivery system in Canada. Most importantly, the results of these activities lead directly to better ways to treat patients, which ensures a healthier and more productive population.*[254]

The Committee also heard that health research could serve as a catalyst to regional economic development and that the health services innovations generated through health research activities could greatly contribute to enhancing the quality and sustainability of Canada's health care system. As health research activity spreads out from the academic health sciences centres and government and into more community-based settings, we can anticipate that standards of care will improve, as health care providers engaged in health research will be better connected with the most recent information. Overall, health research provides tremendous opportunities for both economic and health care progress.

The Committee believes that Canada must actively engage in health research to capture its share of benefits. The Committee also strongly believes that the federal government has a critical role to play as a facilitator, catalyst, performer, consensus builder and coordinator in the overall effort to nurture excellence in health research. This chapter addresses a series of issues, including funding, partnerships and ethics, which we believe deserve close attention if Canada is to achieve the highest standard of excellence in health research.[255]

The Committee believes that Canada must actively engage in health research to capture its share of benefits.

12.1 Assuming Leadership in Canadian Health Research

As Table 12.1 shows, health research in Canada is characterized by a complex network that involves a wide range of disciplines and a multiplicity of performers carrying out their research activities in a variety of locations. In Canada, health research is performed by universities, teaching hospitals, business enterprises, government, and non-profit organizations. This research is financed from a variety of public, private, Canadian and foreign sources.

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[254] Dr. Barry D. McLennan, Chair of the Coalition for Biomedical and Health Research (CBHR), *The Improving Climate for Health Research in Canada*, Brief to the Committee, 9 May 2001, p. 2.

[255] The Committee wishes to say that sections 12.1 and 12.2 of this chapter were inspired by a speech given by Dr. Kevin Keough, Chief Scientist at Health Canada, at the third annual Amyot Lecture organized by Health Canada. We found his lecture very useful in highlighting some of the challenges and opportunities facing health research.

TABLE 12.1
THE CANADIAN HEALTH RESEARCH NETWORK

DISCIPLINES	LOCATIONS	SOURCES OF FUNDING
▪ Clinical Disciplines ▪ Social Sciences and Humanities ▪ Epidemiology ▪ Life Sciences ▪ Cellular and Molecular Biology ▪ Chemistry ▪ Engineering ▪ Computing and Mathematical Sciences ▪ Health Services	▪ Academia (Universities, Teaching Hospitals, Research Institutes) ▪ Industry ▪ Government ▪ Physicians' Practices ▪ Community Organizations ▪ Community Hospitals ▪ Others	▪ Governments (Federal, Provincial, Departments, Funding Agencies) ▪ Non-Government Organizations and National Voluntary Organizations ▪ International Sources ▪ Industry ▪ Universities ▪ Others

The different stakeholders in health research collaborate with each other in various ways: government-university, university-industry, government-industry. In fact, the Committee was told that science is a continuum and the multiple components of health research cannot exist independently of the others. Each component has an important, albeit changing, research role to play in ensuring maximum health benefits for Canadians.

The federal government has always played an important role in health research as a funder, performer and user of research. The federal government financially supports health research carried out in universities, teaching hospitals and research institutes (extramural research); it performs health research in its own laboratories (intramural or in-house research); and it utilizes the outcomes of health research carried out elsewhere. Moreover, the federal government has an important role to play in setting national priorities for health research.

The Committee believes that, in a country as vast as Canada, the federal government has a catalytic leadership role in working with the provincial and territorial governments to ensure that our health care system is driven by research and innovation. To be successful, the federal government needs to have a close collaboration with the provinces and territories to sustain a culture that supports the creation and use of knowledge generated by health research.

The Committee agrees that health research performed, funded and used by the federal government must be of the highest quality. It must be demonstrated to meet or exceed international standards of excellence in science, technology and ethics.

In addition, the Committee agrees with a 1999 report of the Council of Science and Technology Advisors that health research performed, funded and used by the federal government must be of the highest quality. It must be demonstrated to meet or exceed international standards of excellence in science, technology and ethics.[256]

The Committee was informed that, as the cost, complexity and pace of advancement in health research accelerate, individual organizations no longer have the resources or expertise to work in a vacuum:

> *Traditionally, investigators have worked in isolation, pursuing their own research agendas and living grant-to-grant. This scattered, ad hoc approach simply won't work in today's world when the complexity of science requires the pooling of resources.*[257]

At the third annual Amyot Lecture organized by Health Canada, Dr. Kevin Keough, Chief Scientist at Health Canada, stated that it is necessary to adopt an inclusive (or horizontal) approach to health research and to find new ways to partner – that is, to bring together multidisciplinary teams of scientists from across the whole health research system to combine their intellectual, financial and physical resources in conducting the research required to better understand the complex and highly interconnected world in which we live.[258]

The Committee agrees with Dr. Keough that it is critical to sustain effective partnerships and to distribute the effort of individual partners in a manner that will maximize the output of Canadian health research. In our view, complementary and collaborative approaches to health research are not only feasible and cost-effective, but also contribute to better research outcomes for all stakeholders. This overarching goal can only be met if the role of the federal government continues to adapt to the changing health research environment. In addition to being a performer, funder and user of health research, the federal government must become more active as a catalyst and a facilitator.

The Committee agrees that it is critical to sustain effective partnerships and to distribute the effort of individual partners in a manner that will maximize the output of Canadian health research.

The Committee strongly believes that the federal government should assume leadership in Canadian health research and, therefore, we recommend that:

> **Health research and its translation into the health care system be routinely on the agendas of meetings of federal and provincial/territorial Ministers and Deputy Ministers of Health, and that the Canadian Institute of Health Research be represented and be involved in setting the agendas for health research at those meetings. This would greatly help to sustain a culture that supports the creation and use of**

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[256] Council of Science and Technology Advisors, *Building Excellence in Science and Technology (BEST): The Federal Roles in Performing Science and Technology*, December 1999, p. 5.

[257] The Western Canadian Task Force on Health Research and Economic Development, *Seizing the Future – Health as an Engine of Economic Growth for Western Canada*, Summary of the Report, August 2001, p. 2.

[258] Dr. Kevin Keough, Amyot Lecture, October 2001.

knowledge generated by health research throughout Canada.

The federal government set, on a regular basis, national goals and priorities for health research in collaboration with all stakeholders.

The federal government foster multi-stakeholder collaborations when performing, funding and using health research. This should contribute to capitalizing on the best available resources while minimizing overlap and duplication.

Dr. Keough stressed that, as a starting point, the federal government should encourage the interchange of health research scientists between government, academia and the private sector. A freer flow of scientists would enhance the quality of Canadian health research, improve science and research advice to government, maximize the contribution of Canadian scientists to the whole health research community, and contribute to the renewal of the science base in all sectors. The Committee shares similar views and, therefore, recommends that:

The federal government take a leadership role, through the Canadian Institutes of Health Research and Health Canada, in developing a strategy to encourage the interchange of research scientists between government, academia and the private sector, including national voluntary organizations.

The Committee wishes to acknowledge the important role played by national voluntary organizations in health research. These organizations act as a key bridge at the national level between health research and its application through knowledge transfer of information to researchers, health care providers and the general public. It is the view of the Committee that, given the knowledge and experience these national voluntary organizations bring, as well as the significant proportion of the health research enterprise which they support, they must be included in the multistakeholders collaboration in health research.

12.2 Engaging the Scientific Revolution

Witnesses told the Committee that health research in Canada and throughout the world is currently undergoing a scientific revolution. They explained that this revolution in health research is fuelled by the ongoing advances in genomics, engineering and cell biology. Research in these scientific disciplines will have a profound effect on the detection, diagnosis and treatment of various genetically linked diseases. Elucidation of the physiological processes associated with various conditions will require years of efforts to identify the relevant genes and to determine how they interact.

> *We are in the midst of a profound global revolution being driven by our rapidly emerging understanding of the molecular basis of life, of human biology and of disease. Like prior revolutions in science, this revolution is being driven by the collision of diverse disciplines and approaches: genetics, molecular biology, the broader bio-sciences, [information technology] and computational methodologies, small molecules and surface chemistry, bioethics, epidemiology, health economics, and the social sciences and humanities. The pace of this health research revolution is still accelerating, driven by significant global investments by governments, industry and philanthropy.*[259]

As the human genome project approaches completion, the next challenge is to understand the function of the 30,000-40,000 genes that humans appear to possess. These genes encode the entire protein set or proteome estimated at 2 million. Thus, the next frontier in biology appears to be proteomics, the cataloging and functional description of all proteins in living organisms, which is far more complex and promising than genomics.

Similarly, advances in biomedical engineering and miniaturization on the molecular scale will push development of more sophisticated devices for diagnosis and therapy – targeted delivery of drugs, biological testing, molecular imaging, and tissue and organ repair. Canada has a real opportunity to become a world leader in this field of "nanotechnology" or "nanomedicine."

The study and use of stem cells is another good example of the potential impact that health research can have on health and health care. Stem cells have the unique property, whatever their origin, of becoming specialized cells. Currently, both the research community and related stakeholders are very enthusiastic about the potential of stem cells, both from embryonic and adult sources. It is anticipated that research on these cells will lead to treatments for serious diseases such as Parkinson's, Alzheimer's, diabetes and spinal cord injuries. It is also widely believed that these cells can ultimately be manipulated to grow into virtually any tissue or organ thus providing much needed organs for transplant.

Recent research has been successful in programming human embryonic stem cells into producing insulin. Normally, this function is performed by specialized pancreatic islet cells. Should this treatment prove to be able to provide a cure for diabetes, which is presently being treated by regular injection of insulin, it will not only improve the quality of life for the individual, but will also ease the economic burden of disease. In a different study, stem cells isolated from the skin of animals were coaxed into becoming neural, muscular and fat cells.

Other areas where the scientific revolution has a definite impact are chemistry and computer science where advances in molecular modelling combined with synthetic chemistry change the way novel drugs are discovered. Bioinformatics and robotics are also areas that will benefit health research.

The scientific revolution in health research is not limited to basic and biomedical research; it is also creating tremendous opportunities for research into health services and population health. More than ever before, research is undertaken in Canada and abroad to find new ways of delivering quality care and to understand the implications of the interaction of the determinants that affect the health of a population.

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[259] Dr. Alan Bernstein, president of the CIHR, *Health Research Revolution – Innovation Will Shape This Century.*

At the third Amyot Lecture, Dr. Keough stressed that advances in health research, and the need for governments and individuals to accommodate them, will continue to accelerate. This means that governments must be able to both perform and rely on good science, which is based on sound research harnessed for the public good. The government's effectiveness in integrating progresses from emerging areas such as biotechnology and nanotechnology depends on this principle.

The Committee agrees with Dr. Keough that it is imperative for Canada to take up the challenges wrought by the scientific revolution. We are convinced that countries with a strong health research network are more capable of translating advances and innovations into cost-effective health services, modern and internationally competitive policy and regulatory frameworks, new or adaptive products, and new health promotion activities. An energetic health research environment contributes to improved health, higher quality of life, and an efficient health care system. This in turn engenders public confidence, a vibrant business environment and a strong economy.

Along with Dr. Keough, the Committee believes that good science is good economics and that the government has a crucial role in maximizing the gains for Canada and its citizens. Clearly, the costs of doing good science are high; but the costs of not doing it are even higher. These scientific developments are rapidly expanding and there is fierce competition in the field. Along with numerous witnesses, the Committee is convinced that Canada cannot afford to fall behind. The potential pay-off is a fast and economically beneficial transfer of knowledge and its conversion into tangible benefits for the Canadian population.

The Committee believes that good science is good economics and that the government has a crucial role in maximizing the gains for Canada and its citizens.

It is the opinion of the Committee that such a formidable challenge can be met only through a concerted effort by government, industry, academia, non-governmental organizations and international organizations. Each of these partners has its own specific role. However, coordination and support should be provided by the federal government, through its agencies and departments, especially CIHR and Health Canada. Therefore, the Committee recommends that:

> **The federal government, through both Health Canada and the Canadian Institutes of Health Research, coordinate and provide resources to ensure that Canada contributes to and benefits from the scientific revolution to maximize the economic, health and social gains for Canadians.**

The Committee strongly believes that Canada can be a world leader in health research, building on our strengths in human genetics, stem cell biology, population health, bioethics, proteomics, and health economics. We have a tremendous opportunity to apply the knowledge generated from genomics and proteomics research to the study of human populations and human research. For example, the CIHR through its institutes of Genetics and Health Services and Policy Research are partnering with the Federal/Provincial/Territorial Coordinating Committee on Genetics and Health to identify and prioritize emerging issues that can be addressed through research.

The field of genomics and proteomics in Canada could benefit from a more integrated investment approach. For example, with a long-standing record of excellence in protein science research and training, Canada is well positioned to make a significant contribution in proteomics. The Canadian Proteomics Initiative – a partnership between CIHR's Institute of Genetics and the Protein Engineering Network of Centres of Excellence (PENCE) – is working to build on the federal government's investments to date in infrastructure to build a large-scale national program that will ensure that Canada's remains internationally competitive. Therefore, the Committee recommends that:

The Canadian Institutes of Health Research and Genome Canada fund research that positions Canada as a world leader in the new area of genomics and human genetics so that the health care system can take appropriate advantage of this new technology to improve the health of Canadians.

The Canadian Institutes of Health Research play a leadership role in establishing best practices for addressing the complex ethical issues raised by the use of this new technology in health research and health care.

12.3 Securing a Predictable Environment for Health Research

As indicated in Volume Two, the federal government has had a long tradition in financing health research.[260] The most recent estimates by Statistics Canada indicate that the majority (some 79%) of federally funded health research is "extramural" as it takes place in universities and hospitals (68%), private non-profit organizations (6%), and business enterprises (4%).[261]

The principal federal funding body for health research is the Canadian Institutes of Health Research (CIHR). In fact, CIHR is the only federal entity whose budget is entirely devoted to health research. Its creation in 2000 involved a major evolution of the mandate of the Medical Research Council of Canada (MRC) and incorporation of the National Health Research and Development Program (NHRDP), formerly Health Canada's main financing instrument for extramural health research. Despite the creation of CIHR, Health Canada is still involved in the financing of some extramural health research in a wide range of fields (children's health, women's health, Aboriginal health, etc.).

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[260] Volume Two, pp. 93-104.

[261] Statistics Canada, *Estimates of Total Expenditures on Research and Development in the Health Field in Canada, 1988 to 2000*, Catalogue No. 88F0006XIE01006, April 2001.

There are also a number of federal research-oriented bodies whose funding focuses entirely on health-related research. These include namely the Canadian Health Services Research Foundation (CHSRF) and the Canadian Coordinating Office for Health Technology Assessment (CCOHTA). Many feel that for a country of the size of Canada, there are too many federal funding organizations.

In addition, there are several secondary sources of extramural federal health research funding. More precisely, the federal government is responsible for a number of research councils, agencies and programs that devote (to various extents) a portion of their budget for health-related research. These include the Natural Sciences and Engineering Research Council (NSERC), the Social Sciences and Humanities Research Council (SSHRC), the Canada Foundation for Innovation (CFI), the Canada Research Chairs (CRCs), and the Networks of Centres of Excellence.[262] The federal government has also funded Genome Canada, a not-for-profit corporation dedicated to developing and implementing a national strategy in genomic research.

The remainder of the federally funded health research (some 21%) is "intramural" or "in-house" research, that is research conducted in federal government facilities. Federal facilities in which health-related research is performed include Health Canada, Statistics Canada, the National Research Council, Human Resources Development Canada, Agriculture Canada, Environment Canada (in partnership with Health Canada) and the Canadian Food Inspection Agency.

12.8.1 Federal funding for health research

The federal government has, on many occasions, demonstrated its commitment to health research. The Committee applauds the high priority for research given in the 2001 Speech from the Throne and particularly its announcement to increase funding for health research:

> *Our government's overriding goal is nothing less than branding Canada as the most innovative country in the world – as the place to be for knowledge creation; where our best and brightest can make their discoveries; where the global research stars of today and tomorrow are born; becoming the magnet for new investments and new ventures.*
>
> *(…) The Government of Canada will (…) provide a further major increase in funding to the Canadian Institutes of Health Research, to enhance their research into disease*

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[262] The NCEs are supported and overseen by the three Canadian granting agencies (CIHR, NSERC and SSHRC). It is worth noting that eight networks, of the currently funded 22 NCEs, conduct health research in the fields of: arthritis, bacterial diseases, vaccines and immunotherapeutics for cancer and viral diseases, stroke, health evidence application, genetic diseases, stem cells and protein engineering. Some of the other NCEs may have impact on health and health care (e.g. Institute for Robotics and Intelligent Systems or Canadian Water Network).

> *prevention and treatment, the determinants of health, and the effectiveness of the health care system.*[263]

The Committee also recognizes the creation of CIHR as a major achievement in health research. We laud the increased funding for CIHR announced in the December 2001 Budget Speech, despite the severe financial pressures the federal government faces. In addition, the creation of, and funding for, the Canada Foundation for Innovation in 1997, followed by the Millennium Scholarships, the Canada Research Chairs, and Genome Canada, are clear indications that health research and innovation are integral to public health-related policy in Canada.

Throughout its study, the Committee was told that while the increase in federal funding represents significant support for health research, Canada still does not compare favourably with other industrialized countries in this regard. In fact, the role of national government in financing health research, expressed in purchasing power parity (PPP) per capita, is much higher in the United States, the United Kingdom, France and Australia than in Canada. For example, as stated in Volume Two, the American government provided in 1998 four times more funding per capita to health research than did the Canadian government.[264]

Throughout its study, the Committee was told that while the increase in federal funding represents significant support for health research, Canada still does not compare favourably with other industrialized countries in this regard.

Witnesses unanimously recommended that the federal government's share of total spending on extramural health research be increased to 1% of total health care spending in Canada, from its current level of approximately 0.5%. This could involve increasing CIHR's current budget to $1 billion from the current level of $560 million. Additional resources should also be devoted to federally performed health research (discussed in the following section). Overall, increased investment in extramural and in-house health research would bring the level of the federal contribution to health research more in line with that of national governments in other OECD countries. More importantly, this would help maintain a vibrant, innovative and leading edge health research industry.

Another concern brought to the attention of the Committee related to the long-term nature of research in contrast to existing budgetary program planning. High quality research is very competitive internationally and requires long-term commitments. Young researchers, on whom Canada's future in research depends, commit their careers on the basis of their perceptions of the long-term environment for research. Canada will not attract or keep excellent people without providing an excellent environment for research. Research pays little attention to national borders. The world

The Committee strongly supports the view that health research money is money to support the best and brightest minds. Ultimately, Canada's challenge in health research is a challenge to attract and retain outstanding people.

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[263] Government of Canada, *Speech from the Throne*, First Session of the 37th Parliament, 30 January 2001.

[264] Volume Two, p. 97.

recognizes excellence, and competes vigorously for it.

The Committee strongly supports the view that health research money is money to support the best and the brightest minds. At least two-thirds of funds for health research go to salaries and training stipends for highly qualified and motivated researchers, research assistants, technicians, research trainees, etc. Ultimately, Canada's challenge in health research is a challenge to attract and retain outstanding people.

The role of the federal government is central to this competition for excellent researchers. In particular, CIHR is the long-term source of research funds for the health research activities stimulated by the Research Chairs, the Canadian Foundation for Innovation, and Genome Canada, all of which are adding greatly to Canada's capacity for excellence in research. CIHR is also an essential partner for research stimulated by the many health research charities.

Overall, the Committee believes that the federal government must establish and maintain long-term stability in the Canadian health research environment. Providing an adequate and predictable level of funding is a necessary prerequisite. We agree with witnesses that the federal government must increase its investment in health research so that federal extramural funding accounts for 1% of total health care spending.

In our view, such additional federal funding should be directed to research projects that can have a significant impact on health status or that contribute substantially to improvements in health care quality and delivery. Research in such fields as population health, public health, health services delivery, clinical practice guidelines, early child development, and women's and Aboriginal health should be given the highest priority.

The Committee also believes that the establishment of CIHR has resulted in the creation of a broad platform upon which to launch bold new initiatives in health research. Moreover, we believe that CIHR and its 13 Institutes must insist on the translation of knowledge generated by research; this will ensure that the results of health research are translated into action including changes in clinical practice, health care policy, and individual behaviours.

Health research is a long-term investment; many research projects span a researcher's whole career, and grants are usually awarded for three- to five-year terms, which are simply not consistent with the one-year-at-a-time budget allocation to CIHR. Overall, the Committee recommends that

The federal government:

- **Increase, within a reasonable timeframe, its financial contribution to extramural health research to achieve the level of 1% of total Canadian health care spending. This requires an additional investment of $440 million by the federal government;**

- **Recognize that health research is a long term proposition, and therefore set and adhere to clear long-term plans for funding health research, particularly through the Canadian Institutes of Health Research. More precisely, the federal government should commit to a five-year planning horizon for the CIHR budget;**
- **Provide predictable and appropriate investment for in-house health research.**

12.3.2 Federal in-house health research

A report by the Council of Science and Technology Advisors identified a clear need for the federal government to perform in-house research. This report stressed that the federal government must have an adequate research capacity to deliver the following key roles:

- Support for decision making, policy development and regulations.
- Development and management of standards.
- Support for public health, safety, environment and/or defence needs.
- Enabling economic and social development.[265]

In other words, the ability of the federal government to set policy and enforce regulations requires it to have an appropriate in-house research capacity. In addition, the government needs to have access to the highest possible quality scientific and technological information in a time frame that meets its needs. Failure to use the best available data and analysis could expose the government to liabilities for damages caused by those decisions.

The major key player in federal intramural health research is Health Canada, for which this function is critical to the fulfillment of its mandate. The department is mandated to help the people of Canada maintain and improve their health and to ensure their safety. Thus, in addition to access to top-quality scientific and technological information, Health Canada must obtain advice to set policy and enforce regulations. The required in-house research capacity includes expertise in:

- the state and spread of disease;
- ensuring the safety of food, water and health products, including pharmaceuticals;
- air quality issues; and,
- fulfilling health promotion obligations.

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[265] Council of Science and Technology Advisors (CSTA), *Building Excellence in Science and Technology (BEST): The Federal Role in Performing Science and Technology*, 16 December 1999, p. 12. The CSTA consists of a group of external experts providing the federal government with on science and technology issues.

To undertake these responsibilities, Health Canada's researchers must possess independent knowledge and skills over a wide range of scientific disciplines, ranging from the behavioural sciences to cellular and molecular biology. In addition, Health Canada must have an adequate in-house capacity to assimilate, interpret and extrapolate the knowledge obtained from other health research partners. Finally, the department must be able to draw widely on expertise and facilities that are not available in-house.

Overall, the Committee learned that Health Canada has a unique role. In order to meet its mandate, the department must be able to provide the best possible independent science advice related to its legislated responsibilities, to undertake a wide range of scientific activities related to its role as regulator and policy advisor, and to provide evidence-based health services and programs. This unique obligation requires Health Canada to have the necessary science and research capacity to fulfill these three functions.

The Committee feels it is important to acknowledge that Health Canada has taken an important step in ensuring, through the appointment in 2001 of a Chief Scientist, that it possess the ability to meet its mandate. The Chief Scientist and his office play a pivotal role in bringing leadership and coherence to Health Canada's scientific responsibilities and activities by championing the principles of alignment, linkages and excellence espoused by the Council of Science and Technology Advisors.

The Committee strongly believes that there is a clear need for the federal government to perform health research and that it must have the capacity to deliver its mandate. The Committee also acknowledges the importance for Health Canada of partnering with stakeholders outside of government when necessary. Therefore, the Committee recommends that:

The Committee strongly believes that there is a clear need for the federal government to perform health research and that it must have the capacity to deliver its mandate.

Health Canada:

- **Be provided with the financial and human resources in health research that are required to fulfill its mandate and obligations;**
- **Engage actively in the establishment of linkages and partnerships with other health research stakeholders.**

12.4 Enhancing Quality in Health Services and in Health Care Delivery

As indicated on numerous occasions in this report, the Canadian health care delivery system is facing a very serious situation, marked by rising costs, a high degree of dissatisfaction and high expectations. While many recommendations for change to the publicly funded health care system have been made over the years, most of them have not been based on scientific evidence, but rather have been grounded on anecdotal evidence or political posturing. For these reasons, research on all aspects of Canada's publicly funded health care system is, at the present time, very critical for health care policy makers and managers.

Areas in need of more research are varied and include:

- health promotion policies
- disease and injury prevention strategies (at both the individual and population levels)
- determinants of health
- approaches to primary care management
- new modes of remuneration for health care providers and institutions
- decision-making by health care providers and users
- organizational care delivery models
- health care policy management
- health care resources allocation
- impact of selected areas of privatized health care
- pharmaco-economics
- assessment and utilization of health care technology and equipment.

Clinical research and the involvement of health care providers themselves in health research are key elements in ensuring that fundamental research is translated into better health and health care. Clinical trials and large-cohort population health research studies are under-supported in Canada, in part due to the large, long-term financial commitment that is required before such studies can be launched. Urgent investment in training and subsequent career support is needed for clinician investigators in Canada. Harassed by ever increasing demands for clinical service, they find it increasingly difficult to remain competitive in competitions for grants and awards.

In Canada, a wide range of organizations are involved in health services research. It is the view of the Committee that, at this critical time for our health care delivery system, it is essential that this type of research be well funded and that these research centres and their investigators take part in the present debate about the future structure of the Canadian hospital and doctor system and about how the growing gaps in health care coverage can be closed.

The Committee believes that the federal government, given its unique role in health research, should commit a significant investment in promoting, in partnership with the provinces and territories, the adoption of research findings in clinical practice.

Moreover, many studies have shown that there is a major gap between new knowledge and its application in every day medicine. For example, only 46% of elderly patients were given pneumococcal vaccine, though it is the group most at risk for suffering from such infections. Aspirin, although recommended for all adult diabetic patients, was prescribed in only 20% of cases, and counselling on HIV transmission was given to less than 3% of adolescents during physician's office visits.[266] In addition, wide variations in practice patterns and outcomes persist across regions as well as across provinces. The Committee believes that the federal government, given its unique role in health research, should commit a significant investment to promoting, in partnership with the provinces and territories, the adoption of research findings in clinical practice. This must be done while continuing to support new research on priority health issues and the development of new tools, so that in the future this knowledge and the new tools can be translated into and implemented to produce improved health and enhanced health care.

Overall, the Committee acknowledges that more health research should be undertaken in order to enhance quality in health services and in health care delivery. Therefore, we recommend that:

> **The federal government, through the Canadian Institutes of Health Research, Health Canada and the Canadian Health Services Research Foundation, devote additional funding to health services research and clinical research and that it collaborate with the provinces and territories to ensure that the outcomes of such research are broadly diffused to health care providers, managers and policy-makers.**

12.5 Improving the Health Status of Vulnerable Populations

There are many groups in Canadian society that have, for numerous reasons, less immediate access to health services appropriate to their specific needs. Examples include individuals with mental health problems, individuals with addiction problems, people with physical disabilities, some ethnic minorities, women in difficult circumstances, people living in rural and remote communities, the homeless and the poor. The Committee acknowledges that there is an urgent need in Canada to support cross-disciplinary health research that will provide new evidence on the diverse factors that influence health status, and on approaches to improving access to needed health care for vulnerable groups. CIHR has recently set up a strategic plan through three of its Institutes to study this crucial problem, but more resources are needed. Therefore, the Committee recommends that:

> **The federal government, through the Canadian Institutes of Health Research and Health Canada, provide additional funding to health research aimed at the health of particularly vulnerable segments of Canadian society.**

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[266] *JAMA*, vol. 286, p. 1834 (2001).

In Volume Four of its health care study, the Committee stated that the health of Aboriginal Canadians is a national disgrace. There is a disproportionately, and completely unacceptable, large gap in health indicators between Aboriginal and non-Aboriginal Canadians. Aboriginal peoples experience much higher incidence of many health problems, including: significantly higher rates of cancer, diabetes and arthritis; heart disease among men; suicide among young men; HIV/AIDS; and morbidity and mortality related to injuries. Infant mortality rates are twice to three times the national average, with high rates of fetal alcohol syndrome and fetal alcohol effects (FAS/FAE), and poor nutrition. Approximately 12% of Aboriginal children have asthma, in comparison with 5% of all Canadian children. This last trend is attributable, at least in part, to environmental health issues, such as the presence of moulds in houses.[267]

The Committee believes that research is perhaps the most important element that will help improve the health status of Aboriginal Canadians.

The Committee believes that research is perhaps the most important element that will help improve the health status of Aboriginal Canadians. In our view, the creation of CIHR's Institute of Aboriginal Peoples' Health is an important step in this direction. Health Canada, which delivers numerous programs and services to First Nations and Inuit communities, needs to strengthen its research capacity as well as its capacity to translate health research into effective public policy. In particular, Health Canada requires a strong research capacity to:

- compile and analyze available population-based information to identify trends, emerging issues, and differences across geographic regions or communities;
- review programs and services to identify the most effective practices in First Nations and Inuit communities and to assess timely progress in addressing key health issues; and
- maintain and augment the capacity to analyze research both nationally and internationally, and integrate best practice into policy and program development, implementation and evaluation.

Therefore, the Committee recommends as a matter of urgency that:

The federal government provide additional funding to CIHR in order to increase participation of Canadian health researchers, including Aboriginal peoples themselves, in research that will improve the health of Aboriginal Canadians.

Health Canada be provided with additional resources to expand its research capacity and to strengthen its research translation capacity in the field of Aboriginal health.

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[267] Volume Four, pp. 129-135.

Research into the field of health in developing countries is also of concern. The Committee learned that very little research activity is directed towards health problems that affect developing countries. In fact, data suggest that less than 10% of health research is devoted to diseases or conditions that account for 90% of the global disease burden.

The primary causes of morbidity and mortality in developing countries can be grouped under four general areas: malnutrition, poor sexual and reproductive health, communicable diseases, and non-communicable diseases including injuries. A recent report by the World Health Organization shows that long-term economic growth is impossible where large numbers of people are malnourished, sick or dying.

It is the view of the Committee that, given its expertise and excellence in health research, Canada should assume a leadership role in this area. The federal government has taken a step in the right direction. In a first-ever collaborative effort, four Canadian government organizations have joined their forces to formalize a shared commitment to address the problems of global health through research. The Canadian International Development Agency (CIDA), CIHR, the International Development Research Centre (IDRC) and Health Canada have formed the Global Health Research Initiative. Not only will this joint undertaking allow the four partners to operate their programs and research more effectively, it will also contribute to a great humanitarian cause – the health protection of citizens of all countries, including Canadians. This is the beginning; much more needs to be done. Therefore, the Committee recommends that:

The federal government provide increased resources to the Global Health Research Initiative.

12.6 Commercializing the Outcomes of Health Research

One outcome of health research is the creation of new knowledge. New knowledge is in itself of great value to society but the overall impact of health research is maximized when new knowledge is translated into social and economic benefits. Commercialization of health research outcomes represents one way to achieve this knowledge translation.

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Commercialization of health research can happen at many different stages of research and each stage faces different challenges. For example, one of the main challenges facing commercialization of academic health research (occurring in universities and hospitals) is that their early stage of development makes the investment of capital by private sector very risky, thus speculative. By contrast, once a product is marketable, such as the late stage clinical trials (mainly performed by large research-based pharmaceutical firms), the main challenges relate to intellectual property and the patent regime, as well as to approval and monitoring of drugs. Commercialization of health research outcomes brings numerous benefits including:

- improved health, resulting in a more productive workforce;
- enhanced health services quality;
- increased efficiency in health care system delivery;
- expanded research funding leveraged from commercialization and research partnerships;
- enhanced job creation with newly formed companies;
- and greater economic activity from the manufacturing, marketing and sales of new health care products and services.

In its brief to the Committee, the Council for Health Research in Canada indicated that spin-off biotechnology companies formed by CIHR-funded scientists are an important by-product of public investment in health research:

> *For instance, 23 companies have been formed at the University of British Columbia employing 732 people. At McGill, 18 companies have been formed employing 392 people. At the University of Ottawa, 10 companies have been formed employing 459 people. Such companies cannot flourish without public investments to fund a steady discovery pipeline.*[268]

Visudyne is one example of Canadian health research that has produced some powerful advances in health care. The drug, which is approved for use in over 30 countries, is the only approved treatment for age-related macular degeneration, the leading cause of age-related blindness. This treatment was developed at the University of British Columbia (UBC) and was funded, in part, by the federal government. UBC assisted in the start-up of QLT Inc. to commercialize this product that has head offices in Vancouver, employs over 350 people and has a market capitalization of $1.5US billion.

Another example is 3TC, the only inhibitor of HIV reverse transcriptase with few or no side effects and a common component of treatment for HIV/AIDS, which also arose out of federally funded research performed in Montreal. BioChem Pharma Inc., prior to its acquisition by Shire Pharmaceuticals plc. (based in the United Kingdom), had head offices in Montreal, employed 278 people, and had a market capitalization of $3.7US billion.

These examples illustrate the potential of health research to treat disease, create employment and generate economic benefits for Canada. While many academic technologies are licensed to foreign companies, it is reasonable to expect that value should be created and retained in Canada wherever possible and appropriate when the federal government has made investments in health research.

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[268] Council for Health Research in Canada, *Health Research: The Engine of Innovation*, Brief to the Committee, 30 December 2001, p. 2.

As stated in Section 12.2, "good science is good economics." However, during his testimony, Dr. Henry Friesen, Team Leader of the Western Canadian Task Force on Health Research and Economic Development, told the Committee that the conditions are not presently in place to enable publicly funded health research to maximize the returns to Canadian taxpayers.[269] In the opinion of this Task Force, the capacity for research commercialization is sub-optimal and clearly unacceptable.[270]

Similar findings were presented in a 1999 report published by the Advisory Council on Science and Technology (ACST) and prepared by its Expert Panel on the Commercialization of University Research.[271] The Expert Panel made the case that research results from federal funding of university research, where there is commercialization potential, should be managed as an asset that can return benefits to the Canadian economy and Canadian taxpayers. The Expert Panel also showed that the United States has a much better track record in commercialization of university-based research than Canada, despite a growing private sector involvement in funding research at Canadian universities.

Most major research institutions (universities and research hospitals) in Canada have in-house technology commercialization offices that are funded by university sources and, in cases of successful offices, by revenue derived from operation. Currently, the expenses associated with commercialization activities are not covered by direct federal research funding. The Committee learned that the vast majority of these technology commercialization offices have costs that exceed their revenue. They are operated as a cost centre and not as a profit centre for the institution. However, while their function is not critical to the research enterprise (creation of new knowledge), an argument could be made to include costs of operating these offices in the calculation of indirect research costs since technology commercialization is a research-related activity.

The question of funding indirect costs in Canadian research by the federal granting agencies has been one of contention in recent years. It has been recognized as one element to explain the lower level of competitiveness of Canadian researchers. Indirect costs are those expenses associated with administration, maintenance, commercialization and the salary of the principal investigator that is attributable to the research project. The ACST in its 1999 report[272] and subsequent publications has made the recommendation that the federal government increase its investment by supporting the indirect costs of sponsored research. Similarly, the brief of the Council for Health Research in Canada stressed:

> *[The] indirect costs of research must be funded in order to provide a cutting-edge research environment that will fully realize the benefits of the government's Innovation Agenda.*

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[269] See Committee Proceedings, Issue No. 30.

[270] Western Canadian Task Force on Health Research and Development, *Shaping the Future of Health Research and Economic Development in Western Canada*, August 2001, pp. 19-20.

[271] Expert Panel on the Commercialization of University Research, *Public Investments in University Research: Reaping the Benefits*, Advisory Council on Science and Technology, 4 May 1999.

[272] *Ibid.*

> *(…) The Council believes it should be a priority for the government to develop a specific, long-term plan to address this issue as soon as possible.*[273]

The Committee acknowledges that, in its December 2001 Budget, the federal government provided a one-time investment of $200 million through the granting councils to help alleviate the financial pressures that are associated with the rising indirect costs of research activities, including commercialization. We both hope that universities and research hospitals will use some of these funds to improve their commercialization abilities, and that the federal government will make this investment permanently recurrent.

The Committee agrees with witnesses and recent reports that there is a need to find ways to maximize the returns to Canadians from the commercialization of federally funded health research. We believe that the federal government should establish the necessary conditions to enable researchers and those technology commercialization offices providing support and services to researchers to perform to their full potential in commercializing the results of federally funded health research.

The Committee agrees with witnesses and recent reports that there is a need to find ways to maximize the returns to Canadians from the commercialization of federally funded health research. We believe that the federal government should establish the necessary conditions to enable researchers and those technology commercialization offices providing support and services to researchers to perform to their full potential in commercializing the results of federally funded health research.

Further, the Committee believes that CIHR, Canada's premier vehicle for funding health research with a legislated mandate to translate knowledge into improved health, is uniquely positioned to assess the recommendations made by the Western Canadian Task Force, the ACST's Expert Panel and other studies on technology commercialization as they apply to health research. We believe that CIHR should use these reports as the basis for developing and delivering on an innovation strategy that considers programs, policies and people. In our view, such a strategy would see CIHR support and strengthen the capacity of academic technology commercialization offices to maximize the transfer of technologies to market, thereby creating of Canadian companies and jobs and enhancing Canada's innovation capacity. In addition, we believe that this innovation strategy must be developed within a framework that includes governing principles of public good and benefit to Canada so that any strategy to maximize the social and economic impact does not threaten academic freedom or influence the direction of research or the delivery of health care. Therefore, the Committee recommends that:

> **The federal government require an explicit commitment from all recipients of federally funded health research that they will obtain the greatest possible benefit to Canada, whenever the results of their federally funded research are used for commercial gain.**

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[273] Council for Health Research in Canada, Brief to the Committee, p. 5.

The Canadian Institutes of Health Research, while not ignoring the social value of health research that does not result in commercial gain, seek to facilitate appropriate economic returns within Canada from the investments it makes in Canadian health research, whenever the results of investments in Canadian health research are used for commercial gain. In doing so, CIHR should develop an innovation strategy aimed at accelerating and facilitating the commercialization of health research outcomes.

The federal government invest additional resources to enhance the output of Canadian health researchers and strengthen the commercialization capacity of performers of federally funded health research through CIHR's innovation strategy. This new funding would be additional to the current health research investment. In particular, the funding of the indirect costs of research by the Canadian granting agencies should be made permanent. Health research performers should be made accountable for the use of these commercialization funds.

One aspect of the commercialization of health research outcomes that generated controversy recently is the issuance of patents for higher life forms. This subject goes deeply into ethical, intellectual property, and economical issues. Although these questions are highly relevant to Canadian health research and the work of this Committee, they are debated elsewhere. Indeed, the Canadian Biotechnology Advisory Committee (CBAC) has been mandated by the federal government to provide advice on this crucial issue. The CBAC published an interim report on the subject at the end of 2001 where it recommended that human beings at all stages of development, are not patentable.[274] Further, the report recommended that a systematic research program be undertaken to assess the impact of biotechnology patents on various aspects of health services. It is clearly an issue that deserves serious consideration, but is beyond the scope of this report.

12.7 Applying the Highest Standards of Ethics to Health Research

The preceding sections have demonstrated Canada's growing excellence in, and high priority for, health research. However, history has shown that the pursuit of new knowledge in health research can lead, for example, to abuse of the people who are involved as the subjects of research, to invasions of privacy, and to abuse of animals. In various ways, numerous reports have emphasized that new knowledge must not be gained at the expense of abuse of humans and other life forms, and that excellence in health research requires excellence in ethics.

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[274] Canadian Biotechnology Advisory Committee, *Biotechnology and intellectual property: patenting of higher life forms and related issues*, Interim report to the Government of Canada Biotechnology Ministerial Coordinating Committee, Ottawa, November 2001.

But what is ethics? Laura Shanner, Professor at the University of Alberta, told the Committee that "ethics" is a "systematic, reasoned attempt to understand and make the best possible decisions about matters of fundamental human importance."[275] When we refer to ethical issues informed by biological knowledge in medicine, we refer to "bioethics." Dr. Nuala Kenny, Professor of Pediatrics at Dalhousie University (Nova Scotia), defined bioethics as follows:

> *Bioethics is a particular understanding of ethics that brings the discipline of philosophy to assist in making value-laden decisions. It is about the right and the good. It is a practical discipline. Bioethics is ethics in the realm of the biosphere, human biology. It is actually broader than human health, but most people use it in that context.*
>
> *It asks how, in a pluralistic society, do you lay out the values, the issues and the interests at stake when making a decision about the right and the good, generally about an individual patient situation. Then, how do you assist the relevant parties in establishing some kind of priority, so that if there are competing goods or competing harms, you make your choices in a responsible way.*[276]

In many fields, difficult decisions often involve consideration of numerous factors, each implicating different – and often conflicting – values, principles, viewpoints, beliefs, expectations, fears, hopes, etc. When facing such difficult decisions, people may reach different conclusions not only because they consider different factors, but also because they weigh them against each other in different ways. The practical effect of the discipline of ethics is to help those who face complex decisions to identify the inherent values and principles, to weigh them against each other, and to come to the best possible decision. Though based on strong theoretical foundations, ethics in health care and health research deals with real life situations.

Because research seeks constantly to expand the forefront of knowledge, it poses the most challenging questions of ethics. The purpose of this section is to survey some of the major areas of research ethics in terms of the policies and mechanisms now present and/or needed in Canada, to ensure that health research is carried out in a manner that meets the ethical standards of Canadians.

12.7.1 Research involving human subjects

Health research must involve humans as research subjects. While research with other life forms can provide much essential knowledge, in the end only research directly on human beings can tell us, for example, whether a potential new approach to prevention, diagnosis or treatment of disease is safe enough to use in humans, whether it actually helps patients, what its side effects are, and whether it is better than a treatment that is already available.

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[275] Laura Shanner, *Ethical Theories in Bioethics and Health Law*, University of Alberta, Brief to the Committee, 2000, p. 1.

[276] Dr. Nuala Kenny (42:59-60).

Research subjects, often patients with diseases whose treatment is under study, bear the risks of the research so that others may gain from the knowledge that research is intended to provide.

Research subjects, often patients with diseases whose treatment is under study, bear the risks of the research so that others may gain from the knowledge that research is intended to provide. Research involving humans poses many risks: abuse of people, misuse, exploitation, breaches of privacy, confidentiality, etc. Because health research raises such a wide range of issues, an international consensus has developed over the last 50 years or so. This international consensus, which started with the Nuremberg Code (1947) and the Declaration of Helsinki (1964, revised in 2000), requires that the ethical aspects of any research project involving humans be reviewed and approved, with modifications if needed, by an appropriately constituted ethics committee (in Canada called "Research Ethics Board" or REB) before the research project is started.

The Research Ethics Board "is a societal mechanism to ensure the protection of research participants."[277] REBs are multidisciplinary local institution-based boards, independent of the investigator and research sponsor, established to review the ethical standards of research projects within their institutions. They have the power to approve, reject, request modifications to, or terminate any proposed or ongoing research involving human subjects. In effect, the REB attests, for each research protocol, that the proposed research, if it is carried out in the manner agreed to by the REB, meets or exceeds standards of ethics that Canadians expect.

The dominant national policy for the ethics of research involving humans, the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS), was published by CIHR, the SSHRC and NSERC in 1998. The TCPS followed earlier policies (MRC, 1978, 1987, and SSHRC, 1976). The Panel and Secretariat on Research Ethics, launched in November 2001 by the three federal research funding agencies, are responsible for coordinating the evolution and interpretation of the TCPS. The objective is to keep the TCPS up-to-date in response to the rapidly evolving advances in knowledge, research and technology.

The *Tri-Council Policy Statement* has been adopted by academic institutions (where the majority of health research involving humans is carried out) and by some governmental departments and agencies, including the Department of National Defence (DND) and the National Research Council (NRC).

Health Canada is establishing its own Research Ethics Board, which will also use the TCPS, to assess the ethical acceptability of in-house research, research that is contracted to non-Health Canada researchers which requires ethical review and research applications to CIHR or other funding agencies. Health Canada has also adopted the International Conference on Harmonization (ICH) guidelines applying to clinical trials involving the participation of human subjects.[278]

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[277] National Council on Ethics in Human Research, *Protecting Human Research Subjects: Case-Based Learning for Canadian Research Ethics Boards and Researchers*, Ottawa, 2000, p. 7.

[278] Despite the care taken by the three federal granting agencies and Health Canada in the international harmonization of guidelines applying to clinical trials involving human subjects, the Committee would like to be in no doubt that any Canadian participating in clinical trials from outside Canada be protected by ethical standards that are at least as stringent as those applying here.

Since the 1970s, in accord with national policies governing ethics in research involving humans, some 300 local REBs in Canada have been established in a variety of settings including universities, government laboratories, community organizations and teaching and community hospitals. In many teaching hospitals, at least 50% of the research protocols reviewed by REBs are clinical trials that are sponsored by industry for purposes of testing new pharmaceutical interventions in human health so as to meet the regulatory licensing requirements of Health Canada and the USA Food and Drug Administration. In addition, some company-based and private for-profit REBs have developed over the last few years to allow REB review of privately sponsored research outside academic institutions, and hence without access to local REBs. In Alberta, all physicians who are not covered by an institutional REB are required to use the REB of the Alberta College of Physicians and Surgeons. Newfoundland is moving towards establishing a single REB for all health research in the province.

In 1989, the National Council on Ethics in Human Research (NCEHR) was created by the MRC with the support of Health Canada and the Royal College of Physicians and Surgeons of Canada. NCEHR works to foster high ethical standards for the conduct of research involving humans across the country by offering advice on the implementation of the TCPS, primarily through educational activities and site visits to local REBs. NCEHR is now funded by CIHR, SSHRC, NSERC, Health Canada and the Royal College of Physicians and Surgeons.

12.7.2 Issues with respect to research involving human subjects[279]

The *Tri-Council Policy Statement*, in effect Canada's national statement of policy for ethical conduct in health research involving humans, appears to be consistent with world standards. For the most part, REBs in Canada seem to operate to a high standard, building on more than two decades of experience and the dedication of many people across the country. However, the Committee learned that serious gaps have been identified in a number of reports released in recent years by NCEHR and CIHR, as well as by the Law Commission of Canada.[280] A summary of the main issues or gaps identified in these reports is presented below:

- Although the *Tri-Council Policy Statement* sets very high standards, there is currently no oversight mechanism to ensure compliance with these standards. On the one hand, there is no process of certification, accreditation or regular inspection of the research ethics review procedures performed by REBs. On the other hand, and though more REBs are starting to address this issue, few monitor the conduct of research once a research protocol has been approved.

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[279] The following section does not deal with the ethical boundaries surrounding research into human reproductive health as federal legislation is expected to be tabled soon in the House of Commons. The Committee recognizes that this area is at the cutting edge of applied research and evolves rapidly. In our view, all research involving human reproductive material, human organisms derived from such material, other human cell lines, or part of any of them (including human genes) should be subject to full ethical review by REBs and application of the TCPS and other applicable legislation.

[280] More specifically, see the following four reports: 1) NCEHR (formerly National Council on Bioethics in Human Research or NCBHR), "Protecting and Promoting the Human Research Subject: A Review of the Function of Research Ethics Boards in Canadian Faculties of Medicine", *NCBHR Communiqué*, Volume 6 (1), 1995, pp 3-28; 2) Draft report of the Task Force established by the NCEHR to study models of accreditation for human research protection programs in Canada, September 28, 2001; 3) McDonald, Michael (Principal Investigator), *The Governance of Health Research Involving Human Subjects*, research sponsored by the Law Commission of Canada, Ottawa, May 2000; 4) Draft Report of the Task Force on Continuing Review, CIHR, 2001.

In other words, REBs often have limited knowledge of what happens after they have approved a research protocol.

- Some concerns were raised about real or perceived conflicts of interest by researchers or institutions. Though international consensus suggests that REBs would be established within research institutions, and that the work of REBs requires close collaboration with other institutional responsibilities, REBs must be able to operate free from institutional or researcher pressures.
- Similarly, a lack of public oversight of private REBs that act independently or through Contract Research Organizations hired by drug companies raises concerns about their independence and conflicts of interest.
- There is a basic need for more resources for REBs. As the work becomes increasingly complicated with globalization, technology and commercialization, REBs are struggling to find committee chairs or even members.
- There are currently no standard training requirements for Canadian REB members and researchers in research ethics. However, in the absence of similar Canadian standards, Canadian researchers must meet American educational standards for American funded health research involving human subjects.
- The current ethics review processes are "producer-driven" rather than "consumer-driven." In other words, there is a lack of representative participation in governance on the part of research subjects.
- There is an urgent need for empirical research on the effects of health research on human subjects as well as on the effectiveness of the ethics governance procedures.

To sum up, the governance, transparency and accountability of the ethics review processes in Canada need to be improved:

> *(…) we were surprised to see how substantial the gaps were between the ideals expressed in policy and the ground arrangements for accountability, effectiveness and the other criteria for good governance.*[281]

The Committee agrees with many reports that the central concern for Canada is the public accountability of the overall processes for assuring the ethics of research involving humans. We recognize the excellent work that has been done across Canada by dedicated people in many environments who have strived to ensure that health research involving human subjects meets the highest standards of ethics, and we are confident that the standards

The Committee agrees with many reports that the central question for Canada is the public accountability of the overall processes for assuring the ethics of research involving humans.

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[281] Professor Michael MacDonald, Law Commission of Canada.

achieved in Canada are as good as any in the world. Indeed, the report released by the Law Commission of Canada stated:

> *We are also very much impressed with the calibre of scholarly, ethics and legal expertise represented on many REBs. And, at a general level, Canadians scholars are prominent internationally in research regarding legal and ethical aspects of human subjects research.*[282]

We urge the various leading stakeholders of health research involving human subjects to work together to develop a governance system for health research involving human subjects that can meet the following objectives: the promotion of socially beneficial research; the protection of research participants; and the maintenance of trust between the research community and society as a whole.

However, the Committee believes that the present varied structures and approaches to health research ethics are inconsistent with the public accountability that an area of this importance requires. Accordingly, we urge the various leading stakeholders of health research involving human subjects to work together to develop a governance system for health research involving human subjects that can meet the following objectives: the promotion of socially beneficial research; the protection of research participants; and the maintenance of trust between the research community and society as a whole.[283] This initiative should involve Health Canada, CIHR, other federal funding agencies, the Panel and Secretariat on Research Ethics, industrial research sponsors, research institutes, health professional licensing bodies and associations, NCEHR, the newly created Canadian Association of Research Ethics Boards, etc. Therefore, the Committee recommends:

Health Canada initiate, in collaboration with stakeholders, the development of a joint governance system for health research involving human subjects for all research that the federal government performs, that it funds, and that it uses in its regulatory activities.

Health Canada, in the development of this ethics governance system, regard the following components as essential to progress:

- **Work initially on all (health) research that the federal government performs, funds, or uses in its regulatory activities, to develop an effective and efficient system of governance that will become accepted as the standard of care across Canada;**

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[282] *Ibid.*, p. 300.

[283] These objectives correspond to those that were identified in the McDonald report cited in the previous footnote.

- **Give prime importance in the governance system to effective education and training mechanisms for all who are involved in research and research ethics, with certification appropriate to their different responsibilities;**

- **Develop standards, based on the *Tri-Council Policy Statement*, the International Conference on Harmonization guidelines applying to clinical trials involving human subjects, and other relevant Canadian and foreign standards, against which research ethics functions or Research Ethics Boards can be accredited or certified as meeting the levels of function that are consistent with the expectations of Canadians and with those in other countries;**

- **Ensure that the *Tri-Council Policy Statement* is updated and is maintained at the forefront of international policies for the ethics or research involving humans;**

- **Remove inconsistencies between the various policies under which research involving humans is now governed, and make Canadian standards consistent with those of other countries that affect Canadian research;**

- **Establish an accreditation or certification process for research ethics functions that is at arm's length from government, but clearly accountable to government;**

- **Develop the governance system through open, transparent and meaningful consultation with stakeholders.**

12.7.3 Animals in research

Because animals are biologically very similar to humans, animals are used in research to develop new biological knowledge that has a high chance of applicability to the human condition. However, because animals are not identical to humans, new knowledge that arises from research with animals must be tested in humans before it is applied to human health.

Ethical concerns about the use of animals by humanity, particularly their use in research, have been recognized since the 19th century, especially in England. In Canada, these concerns caused MRC and NRC to undertake studies leading in 1968 to the creation of the Canadian Council on Animal Care (CCAC). Currently, CCAC receives 87% of its $1.2 million budget from CIHR and NSERC to cover CCAC services to the research institutions that they fund. CCAC obtains the rest of its revenues from fees for service charged to governmental and private institutions.

CCAC awards the Certificate of Good Animal Practice® to institutions that it determines are in compliance with its standards. Compliance is determined through site visits by assessment panels. CIHR and NSERC make participation in the CCAC program mandatory for all those who wish to receive their research funding and inform institutions that they will withdraw funds from institutions that CCAC states are not in compliance with its standards. The CCAC reports that institutions generally comply with its recommendations.[284]

In its brief to the Committee, the Coalition for Biomedical Health Research stated that CCAC standards are recognized both nationally and internationally:

> *(…) research that complies with CCAC guidelines and policies constitutes ethically sound and responsible activity.*
>
> *(…) CCAC's nationally and internationally accepted standards (…) provide the needed balance between the protection of animals and the benefits that are gained by the use of animals in science.*[285]

The formal structure of the CCAC, along with its monitoring program, is regarded by many, in Canada and abroad, as an optimal model enabling it to work effectively at arm's length from and with government.[286] In addition, recent report suggested that such a model could be considered in the field of research involving human subjects. For example:

> *An interesting model in Canada and one, which I think we need to look at seriously with regard to an accreditation process for human research, is the Canadian Council on Animal Care. (…) it now has remarkable credibility with international recognition. (…) It remains a very interesting and almost uniquely Canadian model. It has federal fiscal support and yet, functioning on its own, setting standards and having a very respected accreditation process for animal research.*[287]

The Committee acknowledges that CCAC performs a world class service to Canadians at a remarkably low cost.

The Committee acknowledges that CCAC performs a world class service to Canadians in a cost-effective manner. Though there is no doubt that some Canadians will disagree, mainly those who reject any use of animals in research, the Committee believes that the CCAC offers clear evidence that a very sensitive area that requires minute by minute attention and care can be effectively managed by an approach based on:

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[284] Louis-Nicolas Fortin and Thérèse Leroux, "Reflections on Monitoring Ethics Review of Research with Human Subjects in Canada", *NCEHR Communiqué*, Summer 1997.

[285] Coalition for Biomedical and Health Research, Brief to the Committee, p. 8.

[286] Sub-Committee on Ethics, *The Ethics Mandate of the Canadian Institutes of Health Research: Implementing a Transformative Vision*, Working Paper prepared for the Interim Governing Council of the CIHR, 10 November 1999, pp. 18-19.

[287] Dr. Henry Dinsdale, Speech to the National Workshop of the NCEHR, March 2001, p. 5.

- Belief, until proven wrong, that institutions and individuals are seeking to work in a manner that reflects the values of Canadians;
- A firm foundation in increasing awareness and training of individuals on issues and standards;
- An assessment approach that is based on internationally recognized standards and that leads to certification of facilities and processes, that involves experts and lay persons, and that operates in a collegial manner until the point when there is evidence of wrongdoing and failure to take the necessary corrective measures.

While not advocating simply copying CCAC's mechanisms into the challenge of governance of research involving humans, the Committee believes that much can be learned from CCAC's experience. The Committee, however, identifies a gap in the interactions between the CCAC and the federal government. Though numerous departments and agencies place themselves under CCAC's assessment program for research involving animals that is carried out in their own facilities, and CIHR and NSERC require compliance with CCAC's standards as a condition of receiving research funds, we believe that this is not enough. Therefore, we recommend that:

All federal departments and agencies require compliance with the standards of the Canadian Council on Animal Care for:

- **All research that is carried out in federal facilities, and**
- **All research that is funded by federal departments or agencies but performed outside federal facilities, and**
- **All research that is carried out without federal funding or facilities, but that is submitted to or used by the federal government for purposes of exercising its legislated functions.**

12.7.4 Privacy of personal health information

All personal information is precious to individuals, but information about personal health is probably the most sensitive to most people. Health information goes to a person's most intimate identity, not only because it directly affects the individual him or herself, but also because it can affect family members and others, as well as other aspects of the person's life, such as his/her employment or insurability.

The right to privacy and confidentiality of personal health information is a very important value for Canadians.

The right to privacy and confidentiality of personal health information is a very important value for Canadians. Now more than ever, Canadians need reassurance that their privacy and confidentiality will be respected in this era of rapidly advancing technology. However, the quality of their health and health care is also a value that Canadians cherish very dearly. Health care providers, health care managers and health researchers need access to personal health information to improve the health of Canadians, strengthen health services and sustain a high quality health care system. The present challenge for Canadians is to set acceptable limits around the right to privacy, on the one hand, and the need for access to information (by health care providers, managers and researchers) on the other, in order to achieve an appropriate balance between them.

The *Personal Information Protection and Electronic Documents Act* or PIPEDA, promulgated in June 2000, has stimulated intensive debate and study of this question in the past two years. The health sector had not recognized the potential effects of this legislation on health research and health care management until the legislative review of the Bill was well advanced through the House of Commons. Representatives from various parts of the health sector therefore intervened strongly in hearings before this Senate Committee in late 1999. Their testimony clearly demonstrated that the health sector was not part of the broad consensus supporting the bill, and also that there was no consensus within the health sector itself as to an appropriate solution to the issues about privacy of health information which are raised by the bill. As a result, the Committee concluded that there was a significant degree of uncertainty surrounding the application of PIPEDA to personal health information that required clarification. In response to the Committee's recommendation[288], therefore, the federal government decided to delay the application of PIPEDA to personal health information until January 1, 2002. This delay would allow one extra year from the time of proclamation to motivate government and relevant stakeholders in the health sector to resolve these uncertainties and formulate a solution that is appropriate for the protection of personal health information.

The Committee is pleased that several groups in the health sector have seriously addressed many of the concerns raised by PIPEDA, and in particular, the need to protect personal health information, while at the same time allow restricted use of such information for essential purposes such as health research and health care management (which includes the provision, management, evaluation and quality assurance of health services).

Over the past two years, CIHR has undertaken a wide-range analysis of the privacy issues and initiated a broad consultation process with various stakeholders, culminating in recommendations for the interpretation and application of PIPEDA to health research.[289]

CIHR's recommendations set out precise legal wording in the form of proposed regulations under PIPEDA that, without changing the Act, would facilitate its interpretation and application in the area of health research. These recommendations were presented to the

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[288] Second report of the Standing Senate Committee on Social Affairs, Science and Technology, 36th Parliament, 2nd Session, 6 December 1999.

[289] CIHR, *Recommendations for the Interpretation and Application of the Personal Information Protection and Electronic Documents Act in the Health Research Context*, 30 November 2001. CIHR's proposed regulations are available on the CIHR Website at http://www.cihr.ca/about_cihr/ethics/recommendations_e.pdf.

Committee as the most realistic, short-term solution, recognizing that PIPEDA would not likely be amended before January 1, 2002. CIHR emphasizes that its proposed regulations, though significantly limited by the current wording of PIPEDA, could nevertheless provide the necessary guidance to help clarify certain ambiguous terms in a manner that will achieve the objectives of the Act without impeding vitally important research. CIHR is also of the view that regulations, as legally binding instruments, are necessary to enable researchers, and Canadians in general, to understand what the law expects of them and how to govern their conduct accordingly. Furthermore, such regulations could provide the necessary basis on which provinces and territories could develop substantially similar legislation before January 1, 2004, as provided for by PIPEDA.[290]

Finally, CIHR recognizes the need for further work with various stakeholders and the provinces to establish an overall, more coherent, comprehensive and harmonized legal or policy framework for the health sector. Ultimately, whatever law or policy governs this area needs to be interpreted and applied in a flexible and feasible manner, and users need to develop more detailed guidelines for promoting best information practices in their daily work.

The Committee has considered the regulations proposed by CIHR and we commend CIHR for its efforts in this regard. We fully support the intent of the proposed regulations. As stated in its Fourteenth Report dated December 14, 2001[291], the Committee believes that these regulations should be given serious consideration and, therefore, we recommend that:

> **Regulations such as those proposed by the Canadian Institutes of Health Research receive their fullest and fairest consideration in discussions about providing greater clarity and certainty of the law with the view to ensure that its objectives will be met without preventing important research to continue to better the health of Canadians and improve their health services.**

A second and parallel initiative was undertaken by a Privacy Working Group composed of representatives from the Canadian Dental Association, the Canadian Healthcare Association, the Canadian Medical Association, the Canadian Nurses Association, the Canadian Pharmacists Association, and the Consumers Association of Canada. The Privacy Working Group addressed the need to access personal health information for the purposes of health care management. In a report submitted to Health Canada, the Privacy Working Group enunciated the following principles.[292]

- Confidentiality of information in health care delivery is of great importance to Canadians. Fear of disclosure to others of personal health information is likely to harm the trust that is essential in the relationship between patients and providers, and hence limits the willingness to seek care, or to impart information that is important to patient care.

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[290] Indeed, the Act gives provinces and territories until January 1, 2004, to develop substantially similar legislation.

[291] Standing Senate Committee on Social Affairs, Science and Technology, *Fourteenth Report*, 37th Parliament, 1st Session, 14 December 2001.

[292] Privacy Working Group, *Privacy Protection and Health Information: Understanding the Implementation Issues*, report submitted to Health Canada, December 2000.

- While an individual's right to privacy of personal health information is of great importance, it is not absolute. This right is subject to reasonable limits, prescribed by law, to appropriately balance the individual's right to privacy and societal needs, as can be reasonably justified in a free and democratic society.
- Individuals have the right to: privacy of their personal health information; decide whether and under what conditions they want such information collected, used or disclosed; know about and have access to their health records and ensure their accuracy; and have recourse when they suspect a breach of their privacy.
- In parallel, health care providers and organizations have obligations to: treat personal health information as confidential; safeguard privacy and confidentiality using appropriate security methods; use identifiable information only with the individual's consent except when the law requires disclosure or there is compelling evidence for societal good under strict conditions; restrict the collection, use and disclosure of personal health information to de-identified information, unless the need for identifiable information is demonstrated; and, implement policies, procedures and practices to achieve privacy protection.

When the Committee met in December 2001 to examine progress made with respect to the application of PIPEDA to health care, we were informed that, while the members of the Privacy Working Group agreed on many issues, they had not yet achieved a definitive and unified position. The Privacy Working Group was of the view that progress towards achieving consensus would require the active involvement and leadership of the federal government. The federal government, however, has taken the position that the concerns of the Privacy Working Group should be resolved between the members of the group and the Privacy Commissioner.

The Committee believes that further guidance and direction is needed in respect of the provision, management, evaluation and quality assurance of health services. For this purpose, constructive and collective efforts by *all* affected parties must be made to address the relevant issues, and government must lead by example. As stated in its 14th Report, the Committee recommends that:

> **Discussions continue among stakeholders, the Privacy Commissioner, and those federal and provincial government departments involved with the provision, management, evaluation and quality assurance of health services.**

The Committee believes that Canadians must engage in a careful and thoughtful consideration of the reasons why personal information is needed for health research and health care management purposes, the social benefits that accrue to Canadians individually and collectively as a result, and the conditions that must be met before access is allowed.

Like other Canadians, the members of the Committee place a very high priority on the protection of personal health information. Though protection of personal health information is understandably of very high importance, we must recognize what else is at risk if access is summarily rejected because of perceived threats to the privacy and confidentiality. Rather than give absolute status to the right to privacy, the Committee believes that Canadians must engage in a careful and thoughtful consideration of the reasons why personal information is needed for health research and health care management purposes, the social benefits that accrue to Canadians individually and collectively as a result, and the conditions that must be met before access is allowed. Because of its long-standing responsibility in funding health care and financing health research, the federal government should play a major role in promoting greater public awareness and facilitating greater debate in regard to these issues.

CIHR's *Draft Case Studies Involving Secondary Use of Personal Information in Health Research* (December 2001) constitutes an excellent model for encouraging discussion and broader understanding through very concrete examples of real health research projects involving secondary use of personal information. Parallel efforts by others to develop similar case studies illustrating why and how personal information is used for health care management purposes would also be extremely valuable. In light of the above, the Committee recommends that:

The federal government, through the Canadian Institutes of Health Research and Health Canada, together with other relevant stakeholders, design and implement a program of public awareness to foster in Canadians a broad understanding of:

- **the nature of, and reasons for, the extensive databases containing personal health information that must be maintained to operate a publicly financed health care system, and**
- **the critical need to make secondary use of such databases for health research and health care management purposes.**

This being said, the Committee believes that if Canadians are to allow restricted access to personal health information for essential functions, such as health research and health care management, it is imperative that their personal health information be adequately protected. We wish to emphasize the importance of ensuring, all the while, that Canadians remain confident that the privacy of their personal health information is being respected. We see here, once again, a major federal role to promote a fulsome discussion of the relevant ethical issues and examination of the control and review mechanisms necessary for ensuring that the secondary use of personal information for health care management and health research purposes is conducted in an open, transparent and accountable manner. Therefore, the Committee recommends that:

> **The federal government, through the Canadian Institutes of Health Research and Health Canada, together with other relevant stakeholders, be responsible for promoting:**
>
> - **thoughtful discussion and consideration of the ethical issues, particularly informed consent issues, involved in the secondary use of personal health information for health care management and health research purposes;**
> - **thorough examination of the control and review mechanisms needed for ensuring that databases containing personal health information are effectively created, maintained and safeguarded and that their use for health care management and health research purposes is conducted in an open, transparent and accountable manner.**

12.7.5 Genetic privacy

The discussion above has addressed issues of privacy of personal health information arising from databases from the existing health care system. The Committee recognizes that new technologies allowing analysis of genes is also introducing new considerations into the management of personal health information. The exploding abilities to link DNA sequences to disease offer the potential both to greatly increase the health care of the individual but also to intrude into the privacy of both the individual and his or her relatives. In addition, these technologies allow the prediction of diseases that have not yet become evident. However, a majority of these predictions represent increased probability of the incidence of the disease, the test being often statistical in nature (e.g., the likelihood is twice that of the general population) rather than absolute (as for Huntington's disease, for example).

The application of the new genetic technologies to human health is as yet in its infancy, but at least some of the potential benefits and harms are becoming evident. The concerns include the fear that access to genetic information on individuals might affect their employability or insurability.

The Committee is pleased that interdepartmental discussions are underway within the federal government on this wide range of issues, and encourages their pursuit to provide guidance and advice on means of addressing these complex issues in the best interests of Canadians.

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12.7.6 Potential situations of conflict of interest

Advances in human health often involve participation of researchers in academia, in government and in industry. The boundaries between these are becoming increasingly blurred, and much mutual trust and collaboration is required between them. For example:

- The large majority of published health research in Canada is done by researchers in academic institutions, who obtain funding from government, philanthropic and industrial sources.
- Academic researchers are increasingly entrepreneurial, and are the source of many start-up companies that are providing fast economic growth in the biological revolution.
- Industries obtain many of their ideas for new commercial entities, including new interventions in health, from academic research, and are starting to establish research centres in academia in exchange for right of first refusal on intellectual property.
- Government regulates health interventions, as well as contributing to knowledge through its in-house research. Regulations depend on research carried out by industry, often in academic institutions, which is assessed by governmental scientists, who may call on academic scientists for advice and other assistance.

The potential for conflicts of interest are obvious, as are the concerns that, for example, industrial interests in protecting intellectual property and commercial interests might adversely affect the performance or publication of research carried out in public institutions or with public funds. Media attention has rightly focused on instances when these fears appear to have been realised.

The Committee is of the view that the majority of industry works to high standards of ethics, fully consistent with the expectations of Canadians. Indeed, companies cannot expect to survive in today's world if they flout society's expectations.

The Committee acknowledges that industrial research is an essential component of health research and health care. In fact, our growing abilities to promote health and to prevent, diagnose or treat disease are very largely due to industry. In addition, despite a number of publicized cases with evidence of conflict of interest, the Committee is of the view that the majority of industry works to high standards of ethics, fully consistent with the expectations of Canadians. Indeed, companies cannot expect to survive in today's world if they flout society's expectations.

However, the Committee understands that the growing role of industry in Canada's health research spectrum, particularly in clinical trials, is a cause for concern. This was highlighted in a recent editorial by the International Committee on Medical Journal Editors, which laid out the ground rules for avoiding conflict of interest in publications.[293] In particular, there is a need to find an appropriate balance between clinical research performed in the academic sector, the ability to compare different treatments for the same disease, the focus of research on diseases in which profits are most likely, (e.g., diseases of wealthy as opposed to poor nations), the publication of negative results (e.g., the need for a registry of all clinical trials), and related areas.

The Committee welcomes the work of CIHR in expanding the collaborative health research programs between academic and industrial research through the University-Industry Program and the CIHR/Rx&D[294] Program. We understand that CIHR partnerships with industry need to be encouraged. However, there is a need to consider whether explicit guidelines should be developed; these guidelines could assist in determining the impact of ethically problematic areas in CIHR's relations with industry. We have learned that CIHR has set up a working group to study this issue. Therefore, the Committee recommends that:

The Canadian Institutes of Health Research, in partnership with industry and other stakeholders, continue to explore the ethical aspects of the interface between the sectors with a view to ensuring that the collaborations and partnerships function in the best interests of all Canadians.

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[293] *See Canadian Medical Association Journal*, 18 September 2001, Vol. 165, pp. 786-788.

[294] Partnership between CIHR and Canada's Research-Based Pharmaceutical Companies.

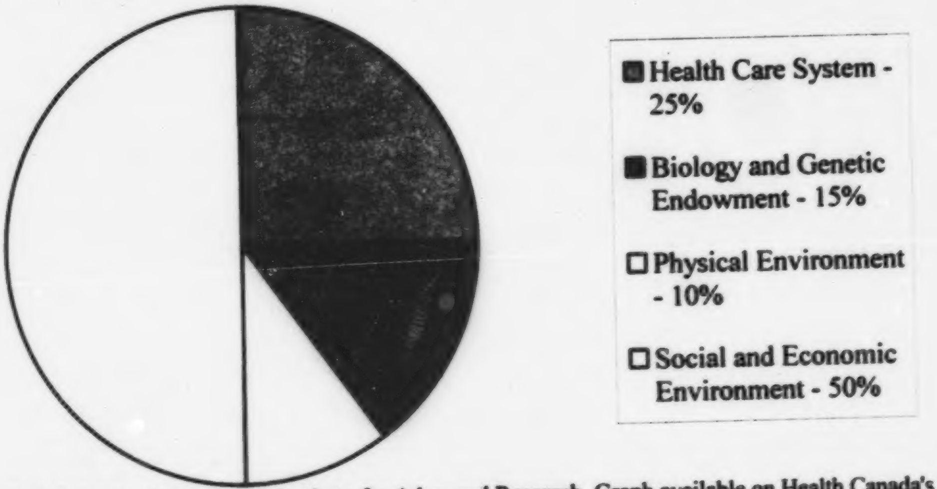
Part VI:
Health Promotion and Disease Prevention

CHAPTER THIRTEEN

HEALTHY PUBLIC POLICY: HEALTH BEYOND HEALTH CARE

As the Committee has noted in Volume One, it is clear that the health care system is an important contributor to good health. Services as widely varied as childhood immunization, medications to reduce high blood pressure or prevent asthma, and heart surgery all contribute to health and well-being. In fact, the Canadian Institute for Advanced Research estimates that 25% of the health of the population is attributable to the health care system alone (see Chart 13.1).[295] Obviously, it is important that the health care sector is fiscally sustainable and continually strives to provide timely services of high quality. Many of the recommendations made by the Committee in this report are designed specifically to achieve sustainability, timeliness, quality and efficiency in health care delivery, all with the objective of improving the health and well-being of Canadians.

CHART 13.1
ESTIMATED IMPACT OF DETERMINANTS OF HEALTH ON THE HEALTH STATUS OF THE POPULATION



Source: Estimation by the Canadian Institute for Advanced Research. Graph available on Health Canada's Website.

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[295] Volume One, p. 81.

The remaining 75% of the health of the Canadian population is determined by a multiplicity of factors outside the health care system. These factors, which are often referred to as the "non-medical determinants of health," include: biology and genetic endowment; income and social support; education and literacy; employment and working conditions; physical environment; personal health practices and skills; early childhood development; gender; and culture.

Throughout its study, the Committee was told repeatedly that, to maintain and improve health status, governments should, in addition to sustaining a good health care system, develop public policies and programs that address these non-medical determinants of health. Such policies and programs encompass a wide spectrum of interrelated activities, ranging from health and wellness promotion, through illness and injury prevention and public health and health protection, to broader population health strategies. These are all components of a healthy public policy:

- **Health and Wellness Promotion:** these activities are designed to encourage Canadians to take a more active role in improving their health through, for example, exercise and healthy food and lifestyle choices.
- **Illness and Injury Prevention:** consists of activities directed toward decreasing the probability of individuals, families and communities contracting specific diseases and injuries. Prevention activities seek to reduce unwanted health outcomes by reducing or eliminating associated risk factors. Immunization, early detection of disease through screening programs and reduction of exposure to potentially injurious activities (use of seat belts in the car, fences around pools, safer roads, etc.) are examples of illness and injury prevention.
- **Public Health and Health Protection**: are intended to protect the health of Canadians against current and emerging health threats. This includes the surveillance and control of disease outbreaks and trends (in both infectious and chronic illnesses) and the monitoring of safety and effectiveness of a variety of products (such as food, drugs and medical devices), as well as environmental health assessments.
- **Population Health Strategies**: include a wide range of government policies and programs that can influence income redistribution, access to education, housing, water quality, workplace safety, and so on – all major determinants of the health of a population.
- **Healthy Public Policy:** is a concept that encompasses health and wellness promotion, disease and injury prevention, public health and health protection, as well as population health. Under a healthy public policy strategy, every major action, program and policy of government is evaluated in terms of its implications for the health of Canadians. Healthy public policy requires an intersectoral approach – one that engages the several sectors that are responsible for, or affect, each of the determinants of health.

There is increasing evidence that investing more human and financial resources in promotion, prevention, protection and population health can significantly improve the health outcomes for a given population. In the end, this can reduce the demand for health services and the pressures on the publicly funded health care system.

The Committee was told and is aware, however, that promotion, prevention, protection and population health activities do not claim anything like the close focus and high status that health care has in the eyes of the Canadian public and, obviously, public policy decision makers. Although it is clear that, collectively, the non-medical determinants of health have far greater impact on the health of the population than health care, the fact is that the very positive outcomes from promotion, prevention, protection and population health activities are generally visible only over the longer term, and thus they are less newsworthy. Because they are less likely to capture the attention of the general public, they are less attractive politically.

The Committee believes that there are enormous potential benefits to be derived from health and wellness promotion, disease and injury prevention, public health and health protection and population health strategies, measured primarily in terms of improving the health of Canadians, but also in terms of their positive long-term financial impact on the health care system.

The Committee believes that there are enormous potential benefits to be derived from health and wellness promotion, disease and injury prevention, public health and health protection and population health strategies, measured primarily in terms of improving the health of Canadians, but also in terms of their positive long-term financial impact on the health care system.

The focus on wellness was recently addressed by the Government of Newfoundland and Labrador in its five-year strategic health plan. The first goal of this plan incorporates a wellness strategy built on health promotion, illness and injury prevention, health protection and early child development.[296] The Committee applauds such initiative.

The Committee strongly supports the opinion of many witnesses that additional funding in these fields is essential for Canada to develop healthy public policies that focus on improving the health and well-being of the population, rather than concentrating only on curing people when they get sick. Moreover, the Committee believes that the federal government can and must play a leadership role in this area.

In this chapter, the Committee sets out its findings and recommendations with respect to the role of the federal government in promoting healthy public policies. Section 13.1 provides information on trends in disease and injury in Canada. Section 13.2 presents data on the economic burden of disease and injury. Section 13.3 discusses the need for a national chronic disease prevention strategy. Section 13.4 examines the concerns raised with respect to public health, health protection and health and wellness promotion. Section 13.5 discusses the broader context of the determinants of health, and highlights the possibilities of moving toward healthy public policy in Canada.

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[296] Minister of Health and Community Services, *Healthier Together: A Strategic Health Plan for Newfoundland and Labrador*, September 2002 (www.gov.nf.ca/health/strategichealthplan).

13.1 Trends in Diseases[297]

During the twentieth century, the application of new knowledge and technology in two key areas – public health (through the provision of clean water and sanitation) and health care – has significantly altered the pattern of disease. The causes of mortality have shifted away from acute, infectious diseases to non-communicable (chronic) diseases (see Table 13.1).

Chronic diseases, such as cancer and cardiovascular disease, are now the leading causes of death and disability in Canada, with accidental injuries the third most common. However, some infectious diseases once thought conquered – such as tuberculosis – are re-emerging as the infectious agents that cause them have developed resistance to antibiotics. Rapid international transport of foods and people also increases the opportunities for the spread of infectious diseases.

TABLE 13.1
LEADING CAUSES OF DEATH (AGE-STANDARDIZED)
RATE PER 100,000

1921-25	
Cardiovascular and renal disease	221.9
Influenza, bronchitis and pneumonia	141.1
Diseases of early infancy	111.0
Tuberculosis	85.1
Cancer	75.9
Gastritis, duodenitis, enteritis and colitis	72.2
Accidents	51.5
Communicable diseases	47.1
All causes	**1,030.0**
1996-97	
Cardiovascular diseases (heart disease and stroke)	240.2
Cancer	184.8
Chronic obstructive pulmonary diseases	28.4
Unintentional injuries	27.7
Pneumonia and influenza	22.1
Diabetes mellitus	16.7
Hereditary/degenerative diseases of the central nervous system	14.7
Diseases of the arteries, arterioles and capillaries	14.3
All causes	**654.4**

Source: Susan Crompton, "100 Years of Health", *Canadian Social Trends*, Statistics Canada, Catalogue 11-008, No. 59, Winter 2000, p. 13.

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[297] Most of the information contained in this section can be found in Volume Two, Chapter Four, "Disease Trends", pp. 45-55.

13.1.1 Infectious diseases

In the early 1920s, heart and kidney diseases were the leading causes of death, followed by influenza, bronchitis and pneumonia, and diseases of early infancy. Tuberculosis took more lives than cancer. Intestinal illnesses such as gastritis, enteritis and colitis, and communicable diseases such as diphtheria, measles, whooping cough and scarlet fever, were also common causes of death.

Public health programs, combined with the large-scale introduction of vaccines and antibiotics, have led to a major shift in the pattern of diseases, with a move away from infectious diseases to chronic diseases. Many infectious diseases persist, however. Indeed, Dr. Paul Gully, Director General at the Centre for Infectious Disease Prevention and Control (Health Canada), told the Committee that the death rate from infectious diseases in Canada has increased since 1980.[298] He pointed to seven infectious disease trends that, in his view, threaten Canadians:

- Many infectious diseases, such as AIDS and hepatitis C, persist;
- There are new and emerging infectious disease threats, including mad cow disease and *E. coli*, as well as the West Nile Virus;
- Global travel and migration can quickly introduce new diseases into the population;
- Environmental changes, such as global warming, deforestation, and tainted water, may increase the spread of infections;
- Behavioural changes, particularly high-risk sexual practices and drug use, can foster the spread of HIV and other infectious diseases;
- Public resistance to immunization could cause a resurgence in, for example, polio and measles;
- Anti-microbial resistance in infectious organisms may reduce the effectiveness of traditional curative measures, such as antibiotics.[299]

13.1.2 Chronic diseases

According to the National Population Health Survey, in 1998-1999, more than half of all Canadians, or 16 million people, reported suffering from a chronic condition. The most common were allergies, asthma, arthritis, back problems, and high blood pressure.[300]

Cardiovascular disease is the leading cause of death in Canada, accounting for 37% of all deaths. Mortality from cardiovascular disease has been declining in Canada since 1970 among both men and women, although more slowly in women. Cancer in its major forms is the second-leading cause of death and is the leading cause of potential years of life lost[301] before age 70 (accounting for over one-third of all potential years of life lost). Cancer is primarily a disease of older Canadians; 70% of new cancer cases and 83% of deaths due to cancer occur among those who are 60 or older. Death rates from cancer have declined slowly for men since 1990, but have remained relatively stable among women over the same period. However, lung cancer rates for women are now four times higher than they were in 1971.

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[298] Dr. Paul Gully, Brief to the Committee, 4 April 2001, p. 2.

[299] Dr. Paul Gully, *op. cit.*, p. 5.

[300] Dr. Christina Mills, Brief to the Committee, 4 April 2001, p. 4.

13.1.3 Injury

In 1995-1996, injuries accounted for 217,000 hospital admissions in Canada. By far the highest rates of hospital admissions due to injuries were among Canadians over the age of 65. Falls remain an important cause of injury among seniors and children under 12. Among children, poisoning was the next most important cause of injury-related admission to hospital in 1996. For adolescents and adults under the age of 65, motor vehicle accidents constituted the second most important cause. The vast majority of injuries are accidental (about 66%).[302]

13.1.4 Mental health

The National Population Health Survey of 1994-1995 found that approximately 29% of Canadians experienced a high level of stress; 6% of Canadians felt depressed; 16% of Canadians reported that their lives were adversely affected by stress; and 9% had some cognitive impairment such as difficulties thinking and remembering. Work prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health estimated that about 3% of Canadians suffer from severe and chronic mental disorders that can cause serious functional limitations and social and economic impairment, such as bipolar personality and schizophrenia. This translates into approximately one in every 35 Canadians over 15 years of age.[303]

Mental stress and disorders leading to mental illness can strike at different periods in life. Autism, behavioural problems and attention deficit disorder most commonly affect children. Adolescence is the typical onset of eating disorders and schizophrenia. Adulthood is a time when depression may manifest itself more obviously. Senior years are marred by Alzheimer's and other forms of dementia, although depression is also often identified in the elderly.

Because of the importance of mental health among Canadians, the Committee will hold specific hearings and table a separate report to present its findings and recommendations to the federal government.

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[301] The internationally recognized indicator of "potential years of life lost" refers to the number of years of life lost when a person dies before a specified age, say age 75. A person dying at age 25, for example, has lost 50 years of life.

[302] Federal/Provincial/Territorial Advisory Committee on Population Health, *Toward a Healthy Future – Second Report on the Health of Canadians*, Ottawa, 1999, p. 19.

[303] Kimberly McEwan and Elliot Goldner, *Accountability and Performance Indicators for Mental Health Services and Supports: A Resource Kit*, prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health, Ottawa, 2000, p. 30.

13.2 The Economic Burden of Illness

The only available estimates on the economic burden of illness and injury in Canada were published in 1997 by Health Canada; they apply to 1993. That year, the total cost of illness and injury was estimated to be $156.9 billion, or 22% of GDP. Direct costs (such as hospital care, physician services and health research) amounted to $71.7 billion, while indirect costs (such as lost productivity) accounted for $85.1 billion.

As Table 13.2 shows, the diagnostic categories with the highest total costs were cardiovascular diseases ($19.7 billion or 15.3% of total costs), musculoskeletal diseases ($17.8 billion or 13.8%), injuries ($14.3 billion or 11.1%), cancer ($13.1 billion or 10.1%), respiratory diseases ($12.2 billion or 9.4%), diseases of the nervous system ($9.6 billion or 7.4%), and mental illness ($7.8 billion or 6%). Infectious diseases accounted for 2.0% of the total economic burden of illness ($2.6 billion).

TABLE 13.2
ECONOMIC BURDEN OF ILLNESS BY DIAGNOSTIC CATEGORY, 1993
(IN MILLIONS OF DOLLARS)

	DIRECT COSTS[1]		**INDIRECT COSTS**		**TOTAL COST**	
	Percent	Cost	Percent	Cost	Percent	Cost
Infectious/Parasitic	1.8	786	2.2	1,857	2.0	2,643
Cancer	7.3	3,222	11.6	9,845	10.1	13,067
Endocrine/Related	3.0	1,334	2.5	2,086	2.6	3,419
Blood Diseases	0.6	274	0.2	173	0.3	447
Mental Disorders	11.4	5,051	3.3	2,787	6.1	7,839
Nervous System/Sense	5.1	2,252	8.6	7,321	7.4	9,573
Cardiovascular	16.7	7,354	14.5	12,368	15.3	19,722
Respiratory	8.6	3,787	9.9	8,393	9.4	12,181
Digestive	7.5	3,326	3.4	2,920	4.8	6,247
Genitourinary	5.1	2,248	0.9	786	2.3	3,034
Pregnancy	4.6	2,025	0.8	690	2.1	2,715
Skin/Related	2.0	892	0.1	122	0.8	1,014
Musculoskeletal	5.6	2,460	18.0	15,328	13.8	17,788
Birth Defects	0.7	305	0.4	334	0.5	639
Perinatal Conditions	1.2	551	0.4	332	0.7	883
Ill-defined Conditions	4.2	1,851	3.0	2,517	3.4	4,368
Injuries	7.1	3,122	13.2	11,222	11.1	14,343
Well-Patient Care	6.2	2,741	0.0	0	2.1	2,741
Other	1.2	549	7.1	6,040	5.1	6,589
TOTAL	**100.0**	**44,130**	**100.0**	**85,123**	**100.0**	**129,253**

A total of $27.6 billion in direct costs were not classifiable by diagnostic category.
Source: Laboratory Centre for Disease Control (Health Canada), *Economic Burden of Illness in Canada, 1993*. 1997, pp. 10-11.

13.3 The Need for a National Chronic Disease Prevention Strategy

These statistics suggest that chronic diseases are not only the leading cause of death and disability in Canada but account for the largest proportion of the economic burden of illness. Moreover, information given to the Committee indicates that about two-thirds of total deaths in Canada are due to the following chronic diseases: cardiovascular disease (heart and stroke), cancer, chronic obstructive lung disease (bronchitis and emphysema) and diabetes.[304] More specifically:

- Cardiovascular diseases, including coronary artery disease and stroke, are responsible for 38% of all deaths among Canadians each year, and are one of the leading reasons for hospitalization.
- Cancer is the second most important cause of death in Canada, responsible for 29% of all deaths each year, and accounting for almost one third of potential years of life lost.
- Chronic obstructive lung disease is the fifth most common cause of death in Canada and is the only cause of death that is increasing in prevalence. Asthma is the most common chronic respiratory disease of children; it is the leading cause of hospital admission and school absenteeism among children in Canada.
- Over one million Canadians live with diabetes. It is a major cause of coronary heart disease and a leading cause of blindness and limb amputations. Among Aboriginal Canadians, the prevalence of diabetes is three times as high as among other Canadians. In total, diabetes accounts annually for about 25,000 potential years of life lost.

During its study, the Committee was told repeatedly that most chronic diseases are entirely preventable. Moreover, a report prepared by Terrence Sullivan, Vice President and Head, Division of Preventive Oncology, Cancer Care Ontario, indicates that many chronic diseases – particularly cardiovascular disease, cancer, chronic obstructive lung disease and diabetes – share common causes. More specifically, poor diet, lack of exercise, smoking, stress and excessive alcohol intake – all lifestyle issues – are recognized as the leading social/behavioural risk factors for these diseases. These risk factors are also often associated with other physical and physiological states that elevate the risk of chronic disease – including overweight/obesity, high blood pressure/hypertension, high blood cholesterol/-hypercholesterolemia, and glucose intolerance/diabetes.[305] If reduced or eliminated, these common lifestyle risk factors would greatly lessen the prevalence and economic burden of these chronic diseases.

The fact that the vast majority of Canadians are exposed to one or more of these common risk factors[306] suggests that the overall health status of the population could be substantially improved by a stronger focus on chronic disease prevention, in parallel with controlling infectious diseases. In recognition of this fact and the potential for joint action, major national health organizations (Canadian Cancer Society, Canadian Diabetes Association, Heart and Stroke Foundation of Canada, Canadian Council for Tobacco Control, Coalition for Active Living, and Dieticians of Canada) have recently come together with Health Canada to form the Chronic Disease Prevention Alliance of Canada (CDPAC).

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[304] Advisory Committee on Population Health, *Advancing Integrated Prevention Strategies in Canada: An Approach to Reducing the Burden of Chronic Diseases*, Discussion Paper, 10 June 2002.

[305] Terrence Sullivan, *Preventing Chronic Disease and Promoting Public Health: An Agenda for Health System Reform*, August 2002.

[306] An analysis from the 2000 Canadian Community Health Survey indicated that 65% of Canadians showed more than one risk factor for chronic disease.

In addition to this new strategic alliance, there are also several important nation-wide chronic disease initiatives, such as: the Canadian Diabetes Strategy, Canadian Heart Health Initiative, Canadian Cardiovascular Disease Action Plan, Canadian Strategy for Cancer Control, and many other federal/provincial/territorial joint initiatives.

However, the Committee was told that there is a need to integrate, coordinate and strengthen all these diverse initiatives into a national chronic disease prevention strategy. According to Sullivan, Canada should build from the knowledge, success and failure of the existing initiatives to push the agenda forward with renewed vigour.[307]

In addition to better integration of the various current initiatives, there is a need for:

- Increased federal leadership, including political leadership and sustained financial and human resources.
- Development of a common vision across all the major chronic disease organizations, leading to a set of specific goals and objectives.
- Partnerships with the provinces/territories and stakeholders in private sector and non-government organizations.
- Surveillance systems for chronic disease and associated risk factors that will also track progress toward the attainment of strategic goals.
- Greater investment in prevention initiatives that are tailored to regional differences.

The national chronic disease prevention strategy should incorporate a combination of public education efforts, mass media programs and policy interventions. These interventions should be implemented through multiple settings (primary health care, education system, workplace, community) and address the need of various priority populations (e.g., Aboriginal Canadians, rural communities, women, etc.).

The direct benefits of a national chronic disease prevention strategy would be substantial, encompassing the avoidance of unnecessary premature disease, enhanced population health status, improved productivity and reduced health care costs. Estimates are that over a ten year period the decreased health care costs resulting from reduced utilization of hospital and doctor services could be as much as 10%.[308]

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[307] Terrence Sullivan, *op. cit.*, p. 7.

[308] Terrence Sullivan, *op. cit.*, p. 10.

The Committee agrees with many witnesses that now is the time for the federal government to lead a national initiative to reduce the prevalence and economic burden of chronic disease in Canada. In our view, the federal government is particularly well suited to assume such leadership, given its long-standing role in health promotion and disease prevention and its legislative authority with respect to health surveillance and health protection.

A national chronic disease prevention strategy will improve the health of Canadians and contribute to the sustainability of the publicly funded health care system. The Committee believes that the Chronic Disease Prevention Alliance of Canada can assist with the design and implementation of this strategy.

The Committee agrees with many witnesses that now is the time for the federal government to lead a national initiative to reduce the prevalence and economic burden of chronic disease in Canada. In our view, the federal government is particularly well-suited to assume such leadership, given its longstanding role in health promotion and disease prevention and its legislative authority with respect to health surveillance and health protection.

While we feel that the federal government must act as a leader, it is important to collaborate with provincial/territorial governments, the private sector, and voluntary health sector partners – if we are to effect the needed changes. Therefore, the Committee recommends that:

The federal government, in collaboration with the provinces and territories and in consultation with major stakeholders (including the Chronic Disease Prevention Alliance of Canada), implement a National Chronic Disease Prevention Strategy.

The National Chronic Disease Prevention Strategy build on current initiatives through better integration and coordination.

The federal government contribute $125 million annually to the National Chronic Disease Prevention Strategy.

Specific goals and objectives should be set under the National Chronic Disease Prevention Strategy. The outcomes of the strategy should be evaluated against these goals and objectives on a regular basis.

13.4 Strengthening Public Health and Health Promotion

A report produced for the Committee by Dr. Joseph Losos, Director of the Institute of Population Health (University of Ottawa), states that public health/health protection often functions silently as the sentinel for health – through monitoring, testing, analyzing, intervening, informing, promoting and preventing – until something happens unexpectedly. In such instances (such as: Walkerton, food-borne outbreaks, infectious disease outbreaks, increasing chronic disease clusters), the crisis and profile of public health incidents quickly reach major proportions. Perhaps most important, often this occurs at a great cost in human suffering, possibly death and financial expense for often preventable occurrences.[309]

According to the *Canadian Medical Association Journal*, a major problem with public health interventions is that funding is low, often unstable or inconsistent. The result is that the public health care infrastructure in Canada is under considerable stress.[310]

Another major barrier to effective public health is fragmentation: all provinces and territories have separate public health legislation. The federal government also has direct statutory responsibilities for regulatory aspects of public health (e.g., disease surveillance, food and drugs, devices, biologics, some environmental health, consumer products). This welter of regulatory authority results in complex negotiations among the various "players" and less than optimal coordinated activity. Such fragmentation limits the effectiveness of public health efforts and results in a lack of clear accountability and leadership. In the view of many experts, there is an immediate need for strong federal leadership to rectify this unhappy and less-than-productive situation.[311]

Similarly, government funding for health promotion is very low relative to spending on health care. In addition, health promotion is practised both by governments and non-government organizations. While most of these efforts have proven effective, their fragmentation has resulted in a poorly coordinated or integrated health promotion infrastructure. More important, no health goals have been set nationally for health promotion as there have been in the United States.[312]

The Committee believes strongly that programs and policies with respect to public health, health protection and health and wellness promotion are critical to enhancing the health of Canadians. We believe that a coordinated and integrated approach is needed and that, once again, the federal government can and should play a leadership role. We believe also that more funding is needed in this area. Given its statutory authority with respect to health protection and its long-standing role in health promotion, the federal government should devote more funding to health protection and promotion. Therefore, the Committee recommends that:

> **The federal government ensure strong leadership and provide additional funding to sustain, better coordinate and**

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[309] Dr. Joseph Losos, ***Promotion and Protection of the Health and Wellbeing of the Population – Vision of Federal/National Roles***, 4 September 2002, p.1.

[310] "Public Health on the Ropes", Editorial, and Richard Schabas, "Public Health: What is to be done?", ***Canadian Medical Association Journal***, Vol. 166, No. 10, 14 May 2002.

[311] Dr. Losos, ***op. cit.***

[312] Dr. Losos, ***op. cit.***, p. 1.

integrate the public health infrastructure in Canada as well as relevant health promotion efforts. An amount of $200 million in additional federal funding should be devoted to this very important undertaking.

13.5 Toward Healthy Public Policy: The Need for Population Health Strategies

As described above, the term "population health" is used to describe the multiplicity and range of factors that all contribute to health. These many factors encompass both the medical and the non-medical determinants of health. The concept of population health is not new. Indeed, for almost 30 years, Canada has played a leading role worldwide in elaborating the concept of population health:

- In 1974, the then federal Minister of Health, Marc Lalonde, released a working document entitled *A New Perspective on the Health of Canadians*. This report stressed that a high quality health care system was only one component of a healthy public policy, which should take into account human biology (research), lifestyle and the physical, social and economic environments. The Lalonde report was extremely influential in shaping broader approaches to health both in Canada and internationally. At the federal level, it led, among other things, to a variety of social marketing campaigns such as ParticipAction, Dialogue on Drinking, and the Canada Food Guide.

- In 1986, the report *Achieving Health for All*, released by the then federal Minister of Health, Jake Epp, led to the initiatives related to Canada's Drug Strategy, the Heart Health Initiative, Healthy Communities, the National AIDS Strategy, etc.

- In 1989, the Canadian Institute for Advanced Research (CIAR), then headed by Dr. Fraser Mustard, proposed that the determinants of health do not work in isolation but that it is the complex interaction among determinants that can have the most significant effect on health. This work, along with more recent findings by Dr. Mustard, has, among other things, led to the development of the joint federal and provincial/territorial initiative on early childhood development.

- In 1994, the population health approach was officially endorsed by the federal, provincial and territorial Ministers of Health in a report entitled *Strategies for Population Health: Investing in the Health of Canadians*.

- In September 2000, all Ministers of Health agreed to give priority to action on the broader, underlying conditions that make Canadians healthy or unhealthy.

There is increasing evidence on the impact of the determinants of health on the health status of Canadians, particularly with respect to the socio-economic determinants. For example, the *Second Report on the Health of Canadians*[313] pointed out that:

- Low-income Canadians are more likely to die earlier and to suffer more illnesses than Canadians with higher incomes;
- Large disparities in income distribution lead to increases in social problems and poorer health among the population as a whole;
- Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy;
- Canadians with high levels of education have better access to healthy physical environments and are better able to prepare their children for school than people with low levels of education. They also tend to smoke less, to be more physically active and to have access to healthier food;
- Studies in neurobiology have confirmed that experiences from conception to age 6 have the greatest influence of any time in the life cycle on the connecting and conditioning of the brain's neurons. Positive stimulation early in life improves learning, behaviour and health right throughout the lifespan;
- Aging is not synonymous with poor health. Active living and the provision of opportunities for lifelong learning are particularly important in maintaining health and cognitive capacity in old age;
- Despite reductions in infant mortality rates, improvements in education levels, and reductions in substance abuse in many Aboriginal communities, First Nations and Inuit people remain at higher risk than the Canadian population as a whole for illness and early death;
- Men are more likely to die prematurely than women, largely as a result of heart disease, fatal accidental injuries, cancer and suicide. Women are more likely to suffer from depression, stress, chronic conditions, and injuries and deaths resulting from family violence;
- Older Canadians are far more likely than younger Canadians to have physical illnesses, but young people report the lowest levels of psychological well-being.

Despite the available evidence, no jurisdiction in Canada and no country in the world has designed and implemented programs and policies firmly based on a population health approach. The fact is that there remain significant practical obstacles to the design of concrete programs that can be sustained over the long haul.

In the first place, the multiplicity of factors that influence health status means that it is extremely difficult to associate cause and effect, especially since the effects of a given intervention are often obvious only after many years. Because political horizons are often of a shorter-term nature, the long timeframe for judging the impact of policy in this area can be a serious disincentive to the elaboration and implementation of population health strategies.

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[313] Federal/Provincial/Territorial Advisory Committee on Population Health, *Toward a Healthy Future - Second Report on the Health of Canadians*, Ottawa, 1999.

Furthermore, it is very difficult to coordinate government activity across the diverse factors that influence health status. The structure of most governments does not easily lend itself to inter-ministerial responsibility for tackling complex problems. This difficulty is compounded several times over when various levels of governments, together with many non-governmental players, are taken into account, as they must be if population health strategies are to be truly effective.

Although many difficulties are associated with developing an effective population health approach, the Committee believes it is important for Canada to continue to strive to set an example by exploring innovative ways to turn good theory into sound practice that will contribute to improving the population's health status.

Moreover, the Committee believes, along with many witnesses, that, given its clear responsibility for so many policies and programs that affect health (health, environment, agriculture, finance, etc.), the federal government should lead the way in population health by coordinating the activities of the different departments concerned. Along with Dr. Losos, we believe the best coordinator would be the federal Minister of Health. As a first step, all policies and programs established by the federal government should be assessed in terms of their impact on the health status of Canadians. Health impact assessment should become a routine component of all new public policies and programs at the federal level.[314]

The Committee believes, along with many witnesses, that given its clear responsibility for so many policies and programs that impact on health (health, environment, agriculture, finance, etc.), the federal government should lead the way in population health by coordinating the activities of the different concerned departments.

Ideally, the Ministers of Health in all Canadian jurisdictions would take on the role of "champions for population health" and advocate health as the major consideration in all initiatives, irrespective of sector. This would lead to the development throughout Canada of a truly "healthy public policy."

In a subsequent report, the Committee will set out its findings and recommendations on the potential for, and the implications of, healthy public policy in Canada.

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[314] Dr. Losos, *op. cit.*, p. 5.

Part VII: Financing Reform

CHAPTER FOURTEEN

HOW THE NEW FEDERAL FUNDING FOR HEALTH CARE SHOULD BE MANAGED

In Volume Five, the Committee stressed its conclusion that, as currently structured, Canada's publicly funded health care system is not fiscally sustainable.[315] Accordingly, there is a need to undertake major reform in the way physician and hospital services are funded in order to preserve and enhance the publicly funded health care system, a system to which Canadians are committed and that has served them so well over the last few decades.

In Volume Five, the Committee stated its view that a *fiscally sustainable health care system* is one upon which Canadians can rely both today and in the future. When considering the system's fiscal sustainability, two interrelated constraints must be taken into account. The first is the willingness of taxpayers to pay for the system. The second is the need for continued economic growth and the corresponding need for governments to keep tax rates at levels that do not diminish Canada's ability to generate investment, create jobs and keep Canada competitive with other OECD countries, and particularly with the United States.[316]

It is the view of the Committee that a fiscally sustainable health care system is one upon which Canadians can rely both today and in the future. When considering the system's fiscal sustainability, two interrelated constraints must be taken into account. The first is the willingness of taxpayers to pay for the system. The second is the need for continued economic growth and the corresponding need for governments to keep tax rates at levels that do not damage Canada's ability to invest, create jobs and keep us relatively competitive with other OECD countries, and particularly with the United States.

To address the question about the fiscal sustainability of the publicly funded health care system, the Committee examined, in its Volume Five, current and projected trends in health care spending.[317] We documented the continuing upward pressures on health care costs due to the rapidly rising costs of drugs and new technology, Canada's aging population, the high and increasing cost of health care human resources and growing public expectations. Based on this information and numerous studies and reports on the increasing costs of health care in Canada, the Committee concluded that Canada's publicly funded health care system, as it is currently operated, is *not* fiscally sustainable given current funding levels.

This chapter examines the implications of this conclusion. Section 14.1 summarizes the multidimensional pressures that, in the view of the Committee, will put considerable additional strain on governments' budgets for health care both in the short and in the long term, and that led us to conclude that more money is needed to sustain the publicly funded health care system and particularly to effect changes to improve its effectiveness and efficiency. Section 14.2 provides the Committee's view on the financing role of the federal government in sustaining a national health care insurance system. Section 14.3 describes a new management system that the Committee believes strongly should be applied to new federal funding for health care.

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[315] Volume Five, p. 7.
[316] *Ibid.*
[317] Volume Five, pp. 7-9.

14.1 More Money Is Needed for Health Care

In Volume Five[318], the Committee examined current and projected trends in health care spending. They are summarized, once again, below.

Data from the Canadian Institute for Health Information (CIHI) show that health care spending in Canada topped $95 billion in 2000, an increase of 6.9% over the previous year. After adjusting for inflation and population growth, there was a real increase in spending of 4.1% between 1999 and 2000.

Data show also that the pace of growth in health care spending is increasing. In fact, real spending per capita is rising faster today than at any time since the 1980s. There are real, continuing upward pressures on Canada's health care costs:

- **Drug Costs**: The cost of drugs currently accounts for over 15% of total (public and private) health care spending. It is forecast to have climbed to $14.7 billion in 2000, up 9% from the year before. The Committee noted in Volume Two that, between 1990 and 2000, drug spending per capita increased by almost 93%, more than twice the average increase for health care spending in total (40%).[319] New, effective, but very costly, drugs are expected to enter the Canadian market in the next decade (vaccine against AIDS, new immunological cure for juvenile diabetes, etc.), further exacerbating upward pressures on overall drug costs.
- **New Technology**: Canada needs to invest more in health care technology and health information systems. The Committee's Volume Two indicated that every $1-billion capital investment in new medical equipment requires an additional $700 million to cover related operating and maintenance costs.[320] In fact, an estimated $2.5 billion in capital is required to bring Canada's investment in health care technology to a level equivalent to that of other OECD countries (see Chapter Ten). Similarly, estimates suggest that between $6 and $10 billion (over a six- to eight-year period) is required to achieve full implementation of a Canadian health info-structure, or between $1 to $1.25 billion annually (see Chapter Ten).
- **Aging Population**: In 1998, 12% of Canadians were 65 or older. That year, more than 43% of provincial and territorial government spending on health care went to services for seniors. According to Statistics Canada, by 2010

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[318] Volume Five, pp. 6-12.

[319] Volume Two, p. 20.

[320] Volume Two, p. 41 and p. 114.

seniors will represent 14.6% of the population, a percentage that rises to 23.6% as the peak of the baby boom generation enters retirement by 2031. Expensive procedures, rarely if ever previously performed on elderly patients, are increasingly available to them.[321] Estimates suggest that the impact of population aging will account for an additional 1% of total health care costs each year. Although this percentage appears to be quite small in the larger scheme of things, in dollar terms it amounts to approximately $1 billion annually in increased health care costs, continuing for decades.

- **Cost of Health Care Human Resources**: Labour costs account for about 75% of spending on health care. According to the report of Premier's Advisory Council on Health in Alberta (the Mazankowski report), in 2001-02 over half the budget increase for health care went to salary increases in that province. This trend is likely to be maintained throughout Canada.
- **Health Research**: Unprecedented support for health research will lead to the development of many new technologies and drugs. This year, some US$40 billion will be spent on health research in the G7 countries, leading to effective, but costly, technologies in the fields of genomics, proteomics, nanotechnology, etc.
- **Growing Public Expectations**: Many observers have noted that increasing public demand for physician and hospital services will have a major impact on future costs. In his interim report, Roy Romanow puts this point very well: "One of the most significant cost drivers is how our own expectations have grown over the past few decades. We expect the best in terms of technology, treatments, facilities, research and drugs, and as a consequence, we may be placing demands on our governments that are not sustainable over time."[322] Canadians are more like North Americans than Europeans when it comes to public expectations. More precisely, 64% of Canadians are very interested in new medical discoveries, compared to 66% of Americans and 44% of Europeans.
- **Health Care Restructuring**: Restructuring, renewing and reforming health care will cost a considerable amount of money. For example, it has been estimated that establishing primary health care teams in Quebec would cost, on average, $750,000 per team (see Chapter Four).
- **Gaps in the Health Care Safety Net**: As pointed out in Chapters Seven, Eight and Nine of this report, currently there are serious gaps in our health care safety net, particularly with respect to prescription drugs, home care and palliative care. Expanding public coverage to reduce or close these gaps in insurance coverage will require additional government funding.

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[321] For example, cardiac procedures (e.g. PTCA) performed on the elderly are increasing by 12% annually; joint surgery (e.g. knee replacement) is increasing at an annual rate of 8%; renal dialysis is increasing by 14% a year (at a cost of $50,000 annually per patient).

[322] Commission on the Future of Health Care in Canada (Roy J. Romanow Commissioner), ***Shape the Future of Health Care, Interim Report***, February 2002, p. 25.

The Committee was told that even conservative projections of future health care costs estimate that those costs will increase by at least one percentage point over the increase in GDP for the indefinite future. Given the publicly funded nature of Canada's health care system, these cost pressures will put considerable strain on governments' budgets, both in the short and in the long term. This has been well documented by provincial and territorial ministers of health in their 2000 report of cost drivers as well as by many reports tabled with the Committee.

For example, a report prepared for the Ontario Hospital Association estimated that close to 38% of total provincial program spending went to health care in 2000-2001, up from 33% in 1992-1993.[323] For its part, the Canadian Taxpayers Federation projected that this proportion will hit 50% as early as 2007 in British Columbia and New Brunswick.[324] Similarly, the Conference Board of Canada estimated that over the period 2000-2020, public per capita spending on health care (adjusted for inflation) will increase by 58%, compared to an increase of only 17% in public per capita spending on all other government services and programs.[325]

This increase in the percentage of government spending devoted to health care provides the clearest indication of the financial pressures felt by governments charged with funding health care. A wide range of witnesses, including health care managers, providers and consumers, expressed deep concerns about rising health care costs and their impact on governments' budgets, both in terms of crowding out other government programs such as education and social services, and imperilling the governments' overall fiscal stability. This testimony and many related reports have persuaded the Committee that, in addition to other necessary reforms, it is essential to invest additional money into Canada's health care system in order to renew and sustain it.

In contrast, a recent report by University of Waterloo Professor Gerard Boychuk contended that there is no fiscal crisis in health care.[326] In his view, there is no fiscal crisis in the sense that Canada's spending on health care has remained relatively constant when taken as a percentage of GDP or as a percentage of overall government revenues. This analysis, however, is presented with a number of caveats. First, it does not consider the projections in health care costs that clearly indicate that health care spending will increase at a rate higher than the growth in either GDP or government revenue. Second, Professor Boychuk recognized the fact that health care is crowding out the provision of other public goods, but considered this as a serious problem only from the provincial perspective, not from the national perspective. This argument avoids the fact that although there are two levels of government involved in funding health care, there is only one set of taxpayers who, no matter where they live, must bear the burden of increasing health care costs. Third, Professor Boychuk argued that the federal government took advantage of the switch from the Established Programs Financing (EPF) to the CHST to reduce its share of health care spending. In his view, publicly funded health care is no longer affordable from a provincial perspective as a result of reduced federal transfers. The logical conclusion to this argument would seem, therefore, to be that the federal government should provide more money for health care.

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[323] TEAQ Associates, *Getting the Right Balance : A Review of Federal-Provincial Fiscal Relations and the Funding of Public Services*, prepared for the Ontario Hospital Association, December 2001, p. 21.

[324] Walter Robinson, *The Patient. The Condition. The Treatment – A CTF Research and Position Paper on Health Care*, Canadian Taxpayers Federation, September 2001, p. 59.

[325] Glenn G. Brimacombe, Pedro Antunes and Jane McIntyre, *The Future Cost of Health Care in Canada, 2000 to 2020 – Balancing Affordability and Sustainability*, The Conference Board of Canada, 2001, p. 21.

[326] Gerard Boychuk, *The Changing Political and Economic Environment of Health Care in Canada*, Discussion Paper, Commission on the Future of Health Care in Canada, July 2002.

The Committee does not support Professor Boychuk's view that the source of the sustainability crisis is political rather than fiscal. We received overwhelming evidence to support our conclusion that the publicly funded health care system is not fiscally sustainable given current funding levels and that, consequently, more money is needed to restructure and renew Medicare and to close the gaps in the existing health care safety net.

Some individuals and organizations disagree with this conclusion. They claim that operating the health care system more efficiently would save enough money so that no new sources of funding would be required. The Committee has always acknowledged the critical importance of improving effectiveness and efficiency in the management and delivery of health services. In fact, the restructuring recommendations outlined in Chapters Two, Three, Four, Six, Ten and Eleven are designed to achieve this objective.

The Committee does not believe that there is sufficient evidence to support the hypothesis that efficiency gains alone will be enough to obviate the need for additional funding. Jack Davis, CEO of Calgary Regional Health Authority and former secretary to the Cabinet in the Government of Alberta echoed this view when he stated:

> *The belief that some magical efficiency will come along that will generate productivity levels in our health care system that are beyond anything that exists anywhere on this planet is naive and unrealistic.*[327]

Canada's publicly funded health care system must be restructured and made much more effective and efficient. But the Committee believes, as it has stated previously, that responsible planning of public policy must include additional funding for health care, including funding the cost of restructuring the system.

Given the federal government's role in the financing of health care, the Committee believes strongly that the government has a critical role to play in sustaining and renewing health care in Canada. We acknowledge, however, that, given all the competing demands for federal government expenditures (e.g., agriculture, the armed forces, the environment, urban infrastructure and so on), any additional funding from federal sources will have to come from *new* money, not from revenue transferred into the health care envelope from existing sources.

The Committee wishes to stress that, given all the competing demands for federal government expenditures (e.g. agriculture, the armed forces, the environment, urban infrastructure and so on), any additional funding from federal sources will have to come from new money, not from revenue transferred into the health care envelope from existing sources.

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[327] Jack Davis (53:59).

We turn, therefore, to confront the most difficult health care issue facing policy makers and indeed all Canadians: how should additional funds for health care be raised? Should these new revenues come from increases in existing taxes, or from new forms of taxation or other levies? Should they come from individuals and/or businesses and flow to government by way of taxes or health care insurance premiums or should they come directly from individuals and/or businesses directly into health care? Jack Mintz, President and CEO of the CD Howe Institute, raised this question eloquently:

> *Governments will need more revenues because of the rising public share of health care costs over time. Therefore, we must think carefully about how we want to fund the public provision of health care. What is the appropriate way of financing that? This is an important question that Canadians should be asking themselves, because that will be an increasing burden for Canadians as a whole.*[328]

Furthermore, in considering how such additional funding ought to be raised, we must keep in mind that Canada's personal taxes are the highest of the G7 countries and among the highest in the OECD. The Committee believes therefore that Canadians must balance their desire for publicly funded health services against both their willingness to pay taxes to fund them publicly and the need for Canadian tax levels to be set so as to maintain our ability to invest and create new jobs, keeping us competitive with other OECD countries, particularly the United States. The Committee's recommendations on how to raise additional federal funding for health care are presented in Chapter Fifteen.

14.2 The Financing Role of the Federal Government

Many witnesses emphasized the fact that historically the federal government has played a major role in financing publicly insured health services. Moreover, public opinion surveys show repeatedly that Canadians want and expect the federal government to continue to be a major player in Canada's publicly funded health care system.

The Committee believes that, to preserve the spirit of the Medicare program that it pioneered several decades ago, the federal government must play a major role in meeting the serious challenges now facing our publicly funded health care system. We reiterate Principle Three from Volume Five: "The federal government should play a major role in sustaining a national health care insurance system."[329]

The Committee believes that the federal government, through its financing role, can facilitate, encourage and accommodate the provinces and territories in their efforts to restructure, reconfigure and renew their health care systems.

The Committee believes that the federal government, through its financing role, can facilitate, encourage and accommodate the provinces and territories in their efforts to restructure, reconfigure and renew their health care systems. The Committee is convinced that the vast majority of Canadians are looking to the federal government to collaborate with, support and form partnerships with the provinces/territories and health care providers to effect needed changes in the health care system. In fact, as discussed in Volume Five, there are many reasons why the federal government's role is important[330].

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[328] Jack Mintz (62:5).

[329] Volume Five, p. 29.

First, Canadians strongly support national principles in health care, and they look to the federal government to play a strong role in setting and maintaining them and to ensure their application throughout the country. As it now stands, the federal government's ability to participate in the development and application of nationwide standards and to recommend appropriate policies to provincial and territorial governments depends in large part on the size of its financial contribution.

Second, and some would say most important, only the federal government is in a position to make sure that all provinces and territories, regardless of the size of their economies, have at their disposal the financial resources to meet the health care needs of their citizens. This redistributive role of the federal government is fundamental to what many call "the Canadian way." From this perspective, Sharon Sholzberg-Gray, President and CEO, Canadian Healthcare Association, stated:

> *(…) we would like to add leadership as an additional role for the federal government. After all, the federal government is the only level of government that can ensure access for Canadians to comparable services, wherever they live in this country. No one provincial or territorial government can ensure that. Only the federal government can do that, and it should take leadership in this area.*[331]

Third, federal funding for health care is particularly critical to reform and renewal of health care; making changes in the way the health care system is structured and operates will surely result in the requirement of more rather than less money, at least in the short term.

Fourth, interprovincial harmonization with respect to what services are insured and scope of practice rules is an important element of a truly national system. The federal government has an key role in facilitating such harmonization (such as, for example, using financial means to help provincial or territorial governments to meet national standards).

The Committee believes strongly that the money that the federal government transfers to the provinces/territories for the purpose of health care should provide it a seat at the table when the restructuring of the health care system is discussed. In our view, the federal government should not give money without having a say on how that money is spent.

Fifth, the Committee believes strongly that the money that the federal government transfers to the provinces/territories for the purpose of health care should provide it a seat at the table when the restructuring of the health care system is discussed. In our view, the federal government should not give money without having a say on how that money is spent. Canadians rightly expect that, when decisions are made about how their tax dollars are to be spent, the government to which they pay those taxes should be represented.

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[330] Volume Five, pp. 12-14.

[331] Sharon Sholzberg-Gray (49:11).

Finally, the Committee is also convinced that there must be stability of, and predictability in, federal funding for public health care insurance. No industry can be expected to operate effectively if, from year to year, its revenue is subject to significant fluctuations over which it has no control. In fact, effective planning, an essential element of an efficiently operated industry, is impossible unless stability and predictability of funding are assured. In other words, multi-year funding is essential if the publicly funded health care system is to be run effectively and efficiently.

14.3 How New Federal Funding for Health Care Should Be Managed

Before turning to the Committee's recommendations with respect to how new additional federal funds for health care should be raised (see Chapter Fifteen), we first address the issue of how such new federal revenue should be managed. The Committee believes that Canadians will be willing to contribute more to public health care spending only *if* they are convinced that the money will actually be spent on health care, and that it will be spent wisely. This requires that the allocation of any new money that Canadians pay to the federal government for health care be subject to a process that is transparent and by which the government can be held accountable by taxpayers.

The Committee believes strongly that new federal funding for health care should be managed according to four distinct but inter-related parameters:

First, increased federal revenue for health care must go into an *earmarked fund* that is separate and distinct from the Consolidated Revenue Fund. We believe Canadians will not agree to pay increased health care contributions to the federal government unless they are assured that the money will be spent on health care, and that the money is truly incremental to the federal government's existing commitment to health care spending. This has been confirmed by a recent survey by Pollara,[332] which indicated that 75% of Canadians would be willing to pay more taxes if such revenue were directed to health care, and not flow into general revenue. Thus, it appears that, for Canadians, health care is unique, different from other publicly funded goods and services: earmarking funds for health care would ensure that public funding remains less susceptible to the vagaries of political decisions with respect to the allocation of government's financial resources.

The Committee believes that increased federal revenue for health care must go into an earmarked fund that is separate and distinct from the Consolidated Revenue Fund.

Second, increased federal revenue for health care must be *targeted*. The Committee is convinced that new federal funding must be used for the purposes outlined in this report, particularly those that would

The Committee strongly believes that new federal money given to the provinces and territories must buy change or reform; additional money should not be used to fund the publicly funded health care system as it is presently structured.

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[332] Pollara, *Health Care in Canada Survey 2002*, June 2002.

expand public health care coverage (as described in Chapters Seven, Eight and Nine) and those that will improve the effectiveness and efficiency of the health care delivery system (such as service-based funding for hospitals, primary health care reform, health care technology, electronic health records, health research and evaluation, and so on). In other words, new federal money given to the provinces and territories must buy change or reform; new money should not be used to fund the operation of the publicly funded health care system as it is presently structured.

Third, and as a corollary to the second point, the Committee is strongly opposed to increased federal funding for health care being given to the provinces and territories under the mechanism of the Canada Health and Social Transfer (CHST). CHST transfers cannot be targeted for specific purposes, nor can the provinces and territories be held accountable for how the money is spent. Similarly, the Committee is equally strongly opposed to the transfer of additional tax points to the provinces and territories. In the first place, the transfer of tax points has a very unequal impact on different provinces. Second, once the tax points have been transferred, the federal government has no authority over how the resulting revenue is spent.

The Committee is strongly opposed to increased federal funding for health being given to the provinces and territories under the mechanism of the Canada Health and Social Transfer (CHST).

Fourth, the Committee is convinced that the federal government should be advised annually on how the money in the earmarked fund should be spent. This advice should be given in the annual report produced by the National Health Care Council, as recommended in Chapter One. The advice given to the government should be made public to ensure transparency and accountability.

The Committee is convinced that the federal government should be advised annually by the National Health Care Council on the priorities that should be attached to expenditures out of the earmarked fund.

And fifth, it is imperative that all governments be made accountable for how additional federal funding for health care is spent. It is the view of the Committee that Canadians must be able to see that the money is being spent for its targeted purposes. Accordingly, both levels of government – federal and provincial/territorial governments – must therefore *share accountability*.

It is the view of the Committee that, from a federal perspective, an annual audit by the Auditor General of Canada of the earmarked fund should detail how the money in the fund has been spent; the results of the audit should be made public.

Similarly, provincial and territorial governments should be required to report annually to Parliament and the Canadian public on their utilization of earmarked health care funds provided by the federal government.

From a federal perspective, an annual audit by the Auditor General of Canada of the earmarked fund should specify how the money in the fund has been spent; the results of the audit should be made public. From a provincial/territorial perspective, their use of earmarked federal funds must be coupled with a requirement for transparent accountability to show the public that the funds have indeed been spent for the specific health care purposes to which they were targeted. In order to do so, provincial and territorial governments should be required to report annually to the Canadian public on their utilization of earmarked health care funds provided by the federal government.

Therefore, the Committee recommends that:

The federal government establish an Earmarked Fund for Health Care that is distinct and separate from the Consolidated Revenue Fund. The Earmarked Fund will contain the additional revenue raised by the federal government for investment in health care.

Money from the Earmarked Fund for Health Care be used solely for the purpose of health care. Moreover, such money must be used to buy change or reform: it must be utilized exclusively for expanding public health care coverage and for restructuring and renewal of the publicly funded hospital and doctor system.

The National Health Care Council be charged with the mandate of advising the federal government on how the money in the Earmarked Fund for Health Care should be spent. The Council's advice to the government should be made public through an annual report.

The federal government subject the Earmarked Fund for Health Care to an annual audit by the Auditor General of Canada. The result of such an audit should be made public.

The federal government require the provinces and territories to report annually to the Canadian public on their utilization of federal money from the Earmarked Fund for Health Care.

If Canadians are indeed willing (as we believe they are) to strengthen the investment by their federal government in health care, and if federal and provincial/territorial governments are willing to collaborate in restructuring and expanding Medicare, then the Committee believes Canada's publicly funded health care system can be made not only fiscally sustainable, but also capable of entering a new era based on its increased efficiency, quality, timeliness, transparency and accountability.

CHAPTER FIFTEEN

HOW ADDITIONAL FEDERAL FUNDS FOR HEALTH CARE SHOULD BE RAISED[333]

As stated in Chapter One of Volume Five as well as earlier in this report, the Committee has received sufficient evidence, based on both the testimony of witnesses and various reports, to conclude that Canada's publicly funded health care system is not fiscally sustainable. It is, therefore, imperative to invest additional money into our health care system in order to renew and sustain it.

Additional funding for health care can come only from the people of Canada, either through the public purse or privately. As shown in Table 15.1, *public funding* can be drawn from general taxation (the primary form of health care financing in Canada, Australia and the United Kingdom) or from dedicated payroll taxes paid by employers and employees and based on labour earnings (as in Germany and the Netherlands). Public funding may also involve public health care insurance premiums (as in Alberta and British Columbia) or an earmarked health care tax (as in Australia). Finally, public funding for health care could be generated from taxable health care benefits, that is, making publicly funded health care benefits received by an individual subject to income tax.[334]

In the view of the Committee, it is imperative to invest additional money into our health care system in order to renew and sustain it.

Additional funding for health care can only come from the people of Canada, through either the public purse or privately.

Private financing sources discussed at the Committee's hearings include various forms of user charges for publicly insured health services, contributions under Medical Savings Accounts (MSAs) or other similar plans, and private health care insurance. In contrast to Canada, user charges for publicly insured health services are required in Australia, Germany, the Netherlands, Sweden and the United Kingdom (amongst other countries). Systems of MSAs are currently in place in Singapore, South Africa and the United States.

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[333] This chapter is based on the testimony received by the Committee as well as on a thorough review of the literature on this topic. In addition, a paper by Robert D. Brown and Michanne Haynes (July 2002) prepared at the request of the Committee, entitled *Financing Options for Funding and Incremental Increase in Federal Spending on the Health Sector*, provided useful guidance in the writing of this chapter.

[334] We are not aware of any country requiring that health care benefits for publicly insured services be taxable, although a number of proposals of this type have been put forward in Canada.

TABLE 15.1
SOURCES OF FUNDING FOR HEALTH CARE

SECTOR	SOURCE
PUBLIC	• General Taxation – which incorporates both direct taxation (personal and corporate income tax) and indirect taxes; • Earmarked Tax– a tax earmarked for a specific purpose, such as taxable health care benefits (whereby the health care costs incurred during a year are added to taxable income); • Payroll Taxes – contributions related to labour earnings and paid by employees and/or employers; • Public Health Care Insurance Premiums – an amount (flat or income-related) paid by everyone for the right to be covered under public health care insurance.
PRIVATE	• User Charges – which correspond to a form of payment made by a patient at the time a publicly funded health service is rendered; • Medical Savings Accounts – health care accounts set up to pay for the health care expenses of an individual or his/her family(a)(b); • Private Health Care Insurance – purchased by individuals or through employers' sponsored plans..

(a) Some proposals suggest that MSAs be funded publicly or, as proposed by some in Canada, as a mixture of public and private sources.

(b) There exists also some other plans involving individual responsibility for some costs but not incurred at the point of service.

Source: Economics Division, Parliamentary Research Branch, Library of Parliament; Brown and Haynes (2002).

Private health care insurance could be used to supplement, complement or replace publicly funded health care. In the event that additional money is not invested into health care as the Committee recommends in this report, or that government fails to ensure timely access to needed care, it is likely that there would be great pressure and, as suggested in Chapter Five, probably a legal obligation on government, to let those Canadians who can afford to do so purchase private health care insurance to obtain privately delivered health services.

Private insurance would, however, move away from the single insurer model that the Committee strongly favours, and would lead to a parallel private delivery system. The potential implications for the publicly funded health care system of allowing private health care insurance in Canada are not discussed in this chapter but are reviewed thoroughly in Chapter Sixteen.

Private insurance would move away from the single insurer model that the Committee strongly favours and would lead to a parallel private delivery system.

15.1 The Amount of Increased Federal Funding Required

The Committee believes that the federal government must provide additional funding for the reform and renewal of the publicly funded health care system. Based on our calculations, implementation of the recommendations given in Chapters Two through Thirteen, when combined with a significant contingency amount that reflects the considerable uncertainty involved in forecasting future costs in the health care field, will require an additional federal investment of approximately $5 billion annually (see Table 15.2).

The amount of $5 billion shown in Table 15.2 is the Committee's estimate of the annual increase in health care costs that would result from expanding public health care insurance to close the gaps in the existing plans (as described in Chapters Seven, Eight and Nine) and from investing in measures to make the current hospital and doctor system more effective and efficient (as described in Chapters Two, Three, Four, Ten, Eleven, Twelve and Thirteen). This amount is ***in addition to*** the current federal contribution to health care (through the CHST and other programs). It is also in addition to any increase in federal funding that may be required to support the ***existing*** hospital and doctor system, as a transition measure until the changes recommended in this report can come into full effect.

TABLE 15.2
ADDITIONAL ANNUAL FEDERAL INVESTMENT NEEDED TO IMPLEMENT THE RECOMMENDATIONS IN THIS REPORT

Expansion and Restructuring	Federal Share (in Millions $)	Additional Information
Expansion of Coverage:		
▪ Post-Hospital Home Care(b)	550	Annually
▪ Catastrophic Drugs(a)	500	Annually
▪ Palliative Care(b)	250	Annually
Improving Efficiency and Effectiveness:		
▪ Health Care Technology (AHSCs) (c)	400	$2 billion over 5 years
▪ Capital Costs (AHSCs) (c)	400	$4 billion over 10 years
▪ Infoway (EHRs) (c)	400	$2 billion over 5 years
▪ Capital Costs (Community Hospitals) (b)	150	$1.5 billion over 10 years
▪ Equipment for Community Hospitals(b)	100	$500 million over 5 years
▪ Primary Health Care Reform(c)	50	$250 million over 5 years
▪ CIHI(c)	50	Annually
Promotion and Prevention:		
▪ Health Promotion and Protection(c)	200	Annually
▪ Prevention of Chronic Diseases(c)	125	Annually
Health Care Human Resources:		
▪ Medical Schools(c)	160	Annually
▪ Nursing Schools and Allied Professions(c)	130	Annually
▪ AHSCs (Post-Graduate Training) (c)	70	Annually
Research, Evaluation and Reporting:		
▪ Research Funded by CIHR(c)	440	Annually
▪ Health Care Commissioner(c)	15	Annually
▪ National System (CCHSA) (c)	10	Annually
Contingency (20%)	1,000	Annually
TOTAL	**5,000**	**Annually**

(a) 90% federal funding.
(b) 50/50 federal and provincial/territorial cost-sharing program.
(c) 100% federal funding.
Source: See the previous chapters.

The Committee believes that the total amount of $5 billion per year in new funding is a realistic sum and an acceptable amount that the federal government, and indeed Canadians through their taxes, ought to be willing to invest in health care on an ongoing basis.

The amounts shown against each purpose in Table 15.2 are estimates. The amount spent for the various purposes listed will vary somewhat from year to year depending on the priority attached to each purpose in any given year. These priorities, and the allocation of funds to each purpose, should be set on an annual basis by the federal government on the advice of the National Health Care Council, as described in Chapters One and Fourteen.

The new federal investment in health care recommended by the Committee *must* be used to support change. It is worthwhile noting that about 30% of the proposed new federal funding will be spent on expanding public health care coverage and on health promotion and disease prevention. About 40% will enhance effectiveness and efficiency of the doctor and hospital system and support increased enrolment in the various health care professions. Some 10% of the proposed expenditures will be invested in health research, outcome evaluation and performance reporting. We have incorporated a 20% annual contingency to provide the necessary flexibility in federal investment.

> ***The Committee acknowledges that some of its recommendations – particularly with respect to post-hospital home care, palliative care and investment in community hospitals – require cost-sharing with the provinces/territories. In our view, these additional costs will not constitute a significant additional financial burden for provincial/territorial governments under these programs, since the federal 50% investment recommended by the Committee would*** **replace** ***money which some of the provinces/territories are now spending in these areas. (...) It is thus fair to say that the Committee's recommendations would generate savings of*** **at least $1.5** ***billion for the provinces and territories.***

It is also worth pointing that, out of the $5 billion in new federal investment, a large proportion is for transitional costs that will decrease as efficiency and effectiveness changes are put in place. Once the 5-year or 10-year period is over, the money used during the transition period will be available for other health care priorities.

The Committee acknowledges that some of its recommendations – particularly with respect to post-hospital home care, palliative care and investment in community hospitals – require cost-sharing with the provinces/territories. In our view, these additional costs will not constitute a significant additional financial burden for provincial/territorial governments under these programs, since the federal 50% investment recommended by the Committee would *replace* money which some of the provinces/territories are now spending in these areas. It is not possible, however, given the limited resources the Committee has at its disposal, to evaluate precisely the extent of these savings to the provinces/territories. Similarly, it is not possible for the Committee to calculate the increased cost to each jurisdiction for the proposed cost-shared programs.

More important, in some of the Committee's recommendations, the federal money directly replaces funds that the provinces/territories would otherwise have to spend. For example, the proposed new federal funding in the areas of health care technology, hospital capital, primary health care reform and human resources –which amounts to some $1.5 billion – would entirely substitute for investment that provincial and territorial governments would have to make in order to reform and renew their health care system. It is thus fair to say that the Committee's recommendations would generate savings of *at least* $1.5 billion for the provinces and territories. This would be in addition to any savings resulting from effectiveness and efficiency gains from our proposed reform, and the Committee expects these savings to be substantial once the changes we recommend are all in place and fully operational.

15.2 Potential Sources of Increased Federal Funding

From which source should the new federal investment in health care come? Should the federal government simply increase the rate of one or more of the existing direct and indirect taxes (general taxation)? Or should the government employ new taxation measures linked specifically to the funding of health care, such as an earmarked tax for health care, or make health care benefits taxable as income, or use earmarked payroll taxes or a national health care insurance premium? Should the federal government also consider an increase in private financing for health care through user charges, MSAs or other plans involving individual responsibility for some health care costs?

This chapter examines these questions in detail. It reviews the advantages and disadvantages of the full range of public and private methods of funding an incremental federal contribution to health care, including general taxation, earmarked taxation, taxable health care benefits, payroll taxes, and public health care insurance premiums. It also provides a discussion of user charges, MSAs and the concept of pre-funding health care.

In considering each of the potential federal revenue sources, the Committee evaluates each of them according to the same set of criteria. These criteria are equity, efficiency, intergenerational fairness, stability and visibility:

- *Equity* deals mainly with income redistribution and social justice. It may be defined as the extent to which contributions to the financing of health care insurance are based on ability to pay (income distribution) as well as the extent to which access to such insurance is based on need (social justice).
- *Efficiency* is concerned with the optimal allocation of resources. A system is efficient if it creates minimum distortions and disincentives in the rest of the economy (in terms, for example, of reduced business investment, lower consumption and living standards, damage to the labour market and job creation, deterioration in international competitiveness, and so on). Efficiency can also encompass cost-effectiveness, that is, the extent to which revenue for health care is generated at the lowest possible administrative and compliance cost.
- *Intergenerational fairness* compares the distribution of the cost burden between younger and older people or between workers and retirees.
- *Stability* refers to the degree of predictability of future funding levels.
- *Visibility* denotes the ability of citizens to link their contributions to government spending on health care (at each level of government) to the benefits that they receive.

These criteria have helped the Committee to decide which source(s) of funding appear(s) to be the most appropriate to raise additional federal revenue for health care.

At the outset, the Committee wishes to emphasize that new financing sources must ensure that the health care system will continue to meet the needs of Canadians in a way that will neither overwhelm other requirements for government finance nor give rise to an unacceptable tax burden on citizens or businesses. The additional revenue requirements must also be structured so as to do the least damage to the economy in terms of job creation and income growth. Moreover, the new revenue sources must make Canadians better aware of the link between the public health care benefits they receive and the taxes that they incur to pay for them.

15.3 General Taxation

Currently, federal funding for health care is derived from general taxation. General taxation is very broad and encompasses both direct and indirect taxes. Direct taxes, which can be levied on individuals, households or corporations, include personal income tax and corporate taxation. Indirect taxes, which are levied on transactions and commodities, include, for example, sales tax, value-added tax and excise taxes.

Currently, none of the direct or indirect taxes that make up federal general taxation offer much visibility or link between the taxes paid and the services received. Indeed, this is the primary reason that many Canadians describe Canada's health care system as being free. The various federal revenues generated through direct and indirect taxation are currently collected into one single fund – the Consolidated Revenue Fund. As a result, there is no direct link between taxation and public health care spending, despite the fact that a substantial part of government revenues are used to pay for health care costs. This contrasts greatly with earmarked taxation (see Section 15.4, below) in which the tax revenue corresponding to the "earmarked" service goes into a designated fund to be used only for that specific purpose.

All forms of direct and indirect taxation have varying implications for equity and efficiency. Direct taxes levied on individuals are frequently progressive: the amount paid rises with income so that high-income people pay proportionately more than low-income people. This leads to a redistribution of income from individuals with higher income to those with less.

Indirect taxes such as sales taxes are usually considered regressive, as the payments are related to consumption of the taxed good or service: high-income people pay proportionately less indirect tax as a percentage of their income (although they pay more in absolute terms). That is, because poorer individuals spend a larger proportion of their income on consumption than richer persons, the burden of a consumption tax falls more heavily on them. However, over a lifetime, consumption is roughly proportional to income over a broad range of earnings; hence, the regressiveness of a consumption tax is not as large as might be initially thought. Further, various offsetting measures, such as the GST Tax Credit, can reduce the regressiveness of a consumption tax.

In his brief to the Committee, Robert Evans, Professor of Health Economics at the University of British Columbia, explained:

> *Taxes are described as progressive if an individual's tax liability rises more than proportionately as income rises, such that higher income individuals not only pay more,*

> *but pay a larger share of their incomes. Conversely, regressive taxation results in lower income people paying a larger share of their incomes in tax.*[335]

The implication of general taxation on equity therefore depends on both the structure of a country's direct and indirect tax systems and the relative amounts of revenue raised by each form of tax.[336] Studies using OECD data suggest that, in countries in which general taxation funds most health care, the mix of direct and indirect taxes used renders the overall taxation mildly progressive.[337]

In 2000, Canada relied on direct taxes for 57% and indirect taxes for 43% of its total taxation revenue. Data also suggest that the Canadian tax system has become more progressive over the last decade: in 1993, Canada collected 49% of its tax revenues from indirect taxes.[338]

When compared with other OECD countries that use tax financing for health care, Canada is above average in its reliance on the personal income tax.[339] In fact, only Denmark, Australia and New Zealand rely to a greater extent on the personal income tax as a percentage of total tax revenues.[340] In terms of its reliance on the corporate income tax, Canada is again slightly above the average of countries with a health care system funded out of general taxation.[341] Finally, Canada is below the average in its use of consumption or indirect taxes, relative to all taxes.[342] Therefore, it could be said that Canada has one of the more progressive tax systems among OECD countries.

From another perspective, however, the fact that Canada has significantly higher personal income tax rates than the United States means that Canada is less attractive for skilled, high-income workers. The higher personal income tax rates also raise the cost of investment capital in Canada derived from personal savings, and therefore discourage investment, productivity and future growth. Indeed, the Committee was told:

> *While a number of factors (higher government debt and social spending) are likely to mean that Canada will continue to have for some time higher personal tax rates than the U.S., it is nevertheless good policy to avoid increasing the spread between US and Canadian rates, and in the long term to reduce these differences. Accordingly, there are major policy reasons for not imposing a significant increase in personal tax rates and widening the personal tax gap with the U.S.*[343]

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[335] Robert Evans, Brief to the Committee, 3 June 2002, p. 2.

[336] Derek Wanless, *Securing our Future Health: Taking a Long-Term View*, Interim Report, November 2001, p. 51. (http://www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_interimrep.cfm).

[337] Elias Mossialos and Anna Dixon, "Funding Health Care in Europe: Weighing up the Options," Chapter Twelve in *Funding Health Care: Options for Europe*, 2002, pp. 272-300.

[338] According to Statistics Canada's data taken from CANSIM II, Table 380-0022.

[339] Caroline Chapain and François Vaillancourt, "Le financement des services de santé au Québec," in *Le système de santé québécois: Un modèle en transformation*, edited by C. Bégin, 1999, pp. 101-121.

[340] OECD (2000), *Revenue Statistics 1965–1999*, Table 11.

[341] OECD (2000), Table 13.

[342] OECD (2000), Table 27.

[343] Brown and Haynes (2002), p. 13.

Similarly, the Committee heard that it would be difficult and inadvisable to increase corporate income tax to support the incremental costs of increased federal spending on health care. The base for corporate taxation is smaller than the base for personal income tax or a payroll tax, and is also much more variable. Furthermore, increasing corporate tax rates would have a very negative impact on rates of return on capital investments in Canada, and therefore would discourage both investment and job creation. Even existing businesses could be influenced to relocate outside of Canada in response to what would be a very significant increase in tax burdens. Overall, many witnesses argued that the corporate tax is unsuitable for raising additional revenues to finance health care.

The Committee was told that with an increase in the federal personal income tax there would be significant costs to efficiency, measured in terms of labour supply, savings and investment. We were told that a tax on income imposes a "double tax" on savings, since the income out of which savings are made is subject to income tax, and then the returns on the savings are themselves subject to additional tax.

Nevertheless, because financing the health care system by general taxation draws revenue from a wide base, it helps to minimize the distortions taxation creates in the economy. Furthermore, financing health care through general taxation involves low administrative costs.[344]

Under general tax-financed systems, as opposed to those financed by earmarked taxes, decisions about how much should be spent on health care necessarily require trade-offs to be made among other government spending priorities, such as social programs or tax or debt reduction. As a result, funding health care through general taxation means that the allocation to health care is subject to spending negotiations within government. While this provides some element of accountability, it also greatly politicizes the decision-making process.

Another disadvantage of funding health care through general taxation is that it can leave the health care system vulnerable in times of economic slowdown or fiscal constraint. Economic slowdowns result in lower tax revenues and increased pressures to reduce public spending. This, therefore, negatively affects the stability of health care funding. It should be noted, however, that all tax revenues fluctuate with the economy and that general revenues tend to fluctuate less than many specific forms of taxes.

Finally, and perhaps most important, witnesses stressed that direct and indirect taxation do not have the same impact in terms of intergenerational fairness. Personal income tax extracts a greater proportion of government revenues from the younger working population than from retirees. Thus, Canada's changing demographics, which reflect a rise in the proportion of retirees relative to the working population, would be associated with a decreasing tax base and smaller revenues for any given income tax rate. As a result, the use of direct taxation, particularly personal income tax, to finance the publicly funded health care system could involve significant subsidization of the health care needs of the elderly by the younger working population. In this perspective, Jack Mintz, President and CEO of the C.D. Howe Institute, told the Committee that:

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[344] Derek Wanless (2001), p. 50.

> *In fact, the OECD has estimated that, as the population ages, the tax/GDP ratio in Canada will fall by 1.5 points. This is because elderly people, once they retire, tend to have lower incomes and, therefore, pay less tax than workers. There may be some taxes that would be better if you were going to fund health care expenditures, because the majority of health care expenditures are weighted heavily toward the elderly in the last years of their lives. Therefore, as the population ages and the benefits paid out to the elderly increase, if you have taxes that are particularly falling on working Canadians they will have to bear a bigger responsibility for those benefits.*[345]

In contrast, the Committee was informed that demographic changes have less impact on government revenue generated through indirect taxation, such as a consumption tax. Moreover, consumption taxes may be preferable, on the grounds of economic efficiency, to corporate income tax. David Stewart-Patterson, Senior Vice-President, Policy, Canadian Council of Chief Executives, stressed that point when he stated:

> *In considering tax policy, however, we must remember that not all taxes are equal in terms of their economic impact. As the Department of Finance has estimated, an extra dollar of revenue raised through corporate taxes may do nine times as much damage to economic growth as a dollar raised through sales tax. The more Canada chooses to spend on health care through the public system, therefore, the more it will have to shift its tax mix toward a consumption base in order to remain competitive.*[346]

Jack Mintz from the C.D. Howe Institute held similar views:

> *(…) consumption taxes have been found to have lower distortionary costs to the economy and they tend to be more efficiently imposed. They are smoother than, for example, income taxes over the life cycle of individuals because working income tends to peak during working lives before falling off in retirement years. At the same time, consumption tends to be lower than income during the years in which people are accumulating savings, and consumption tends to be high in retirement years relative to income as that is when people are drawing down assets to consume during their retirement years. Consumption taxes also tend to be proportional to the consumption of individuals over a life cycle. One could make it progressive by having a tax credit, such as the GST tax credits which provides relief, particularly for lower income Canadians.*[347]

David Kelly, former Deputy Minister of Health in British Columbia, also suggested that consumption taxes generate less distortion in the economy:

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[345] Jack Mintz (62:6).

[346] David Stewart-Patterson, Brief to the Committee, 17 June 2002, p. 4.

[347] Jack Mintz (62:7).

> *If the decision has been taken to increase funding for health care and the question is what should be the revenue source, I would do exactly what the B.C. government did a few months ago when it discovered that it did not have sufficient revenue to cover rising health care costs – it increased the consumption tax.*
>
> *(...) I say that for three reasons. First, it raises revenue quickly. Second, we have to keep our income tax, corporate tax, payroll tax and so on within shooting distance of the Americans, which significantly constraints our policy flexibility. Third, it is a visible tax. It would make consumers fully aware of the implications of health care cost increases. It might bring additional consumer pressure to bear on the cost side of the equation which, from my point of view, would be healthy.*[348]

To sum up, the decision to consider direct versus indirect taxation as a means of increasing federal revenue for the purpose of health care will necessarily require that some trade-off be made between equity, intergenerational fairness and efficiency. The testimony received by the Committee suggests that the objective should be first of all to ensure that any new tax is as efficient as possible so that it causes as little damage to the economy (including job creation and economic growth) as possible, and then subsequently to achieve whatever progressivity is desired in the system through supplementary measures such as low-income tax credits or high-income surtaxes.

15.4 Earmarked Taxation

Earmarked taxes are taxes from which the revenue is dedicated to a specific use. Earmarked taxes can be either direct or indirect. An earmarked tax for health care has several advantages over general taxation. For example, it may reduce public resistance to paying the tax because it is clearly associated with a use that provides benefits to the public. Establishing genuine linkage between taxation and spending makes the funding of health care more transparent and responsive. Another advantage of earmarking taxation is that it makes people feel more connected to the tax system which, in turn, may increase the pressures on health care providers and institutions to improve quality and access to services. Earmarked revenues may also be more stable since they are less susceptible to the vagaries of political decisions with respect to the allocation of the government's financial resources.

Many witnesses presented strong arguments in favour of earmarked taxes. In the view of these witnesses, earmarking taxes for health care is what Canadians want. For example, Dr. Les Vertesi, Chief of the Department of Emergency Medicine at the Royal Columbian Hospital (Vancouver), told the Committee:

> *I believe that the public is prepared to put more money into their public health care system, but not into taxes that go into general revenue. It is a trust issue. The record on governments taxing people and then ensuring that money goes into designated services is not good, or at least certainly the perception is that it is not good. The trust has been*

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[348] David Kelly (59:40-41).

> *broken. People do not want to give money to governments and have it just disappear. They are prepared to do so if they are assured that the money will go into health care, and especially into health care in their local area (...).*[349]

There are, however, a number of disadvantages associated with earmarked taxes. Not all taxes that bear the name or appearance of an earmarked tax are strictly earmarked to an identified use in practice. This is particularly true if the revenue from the earmarked tax is merged together with other tax revenues. This weakens the connection between revenue and expenditure and consequently undermines the population's trust that the tax will be devoted to the named purpose. For a tax to be effectively earmarked, the revenue it generates must go into a specific, dedicated fund, and not into the Consolidated Revenue Fund.

Earmarking taxes also introduces rigidity into the government budgetary process, because expenditure on the program for which the tax is earmarked is determined by the revenue generated and not by policy decisions. Another disadvantage is that the revenue derived from a single earmarked tax can be cyclical and susceptible to variability in periods of economic expansion or slowdown.

Also, separating health care from other areas of public spending might lead to pressure to have other budget items funded separately by earmarked taxes. If this happened in a number of areas it would make it difficult for the government to generate a large enough Consolidated Revenue Fund to be able to pay the cost of necessary but less popular government programs, such as foreign aid. Thus, having a large number of earmarked taxes is simply not workable.

In Volume Four, the Committee presented an option under which the cost of publicly funded health care that an individual receives during a year be treated as a taxable benefit for that year. Thus, the individual would pay income tax on the cost of the health services provided, subject to an annual maximum. This method of taxation would raise additional revenue for health care and promote individual accountability for the use of health care.[350] Under this option, which corresponds to one form of earmarked tax, individuals would be required to add the cost of the health services that they received during the year to their taxable income. Such an option has been advocated in recent years, particularly by Jack Mintz *et al.* (1998),[351] Tom Kent (2000)[352] and most recently by Mintz, Aba, and Goodman (2002).[353]

Under the plan proposed by Mintz, Aba and Goodman, individuals would be charged a tax of 40% of the health care costs they incurred during the year, up to a maximum of 3% of the individual's annual income. Families with an income of less than $10,000 would be exempt from paying tax on any service they received through the publicly funded health care system. Under this scheme, the more an individual used the services of the health care system, the higher the individual's contribution to the system would be in that year, up to the maximum 3% of income.

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[349] Dr. Les Vertesi (53:62).

[350] Volume Four, pp. 63-64.

[351] Jack Mintz, Michael Gordon and Duanjie Chen, "Funding Canada's Health Care System: A Tax-Based Alternative to Privatization," in *Canadian Medical Association Journal*, 8 September 1998, pp.493-496.

[352] Tom Kent, *What Should Be Done About Medicare*, The Caledon Institute of Social Policy, August 2000.

[353] Jack Mintz, S. Aba and W.D. Goodman (2002), "Funding Public Provision of Private Health: The Case for a Copayment Contribution through the Tax System," *C.D. Howe Institute Commentary – The Health Papers*, No. 163.

Mintz, Aba and Goodman argued that, by relating the individual's contribution to the actual health services that are used, and by encouraging users to consider the costs, efficiency would be gained in the use of health care resources. The authors also contended that limiting individual health care taxes to a maximum of 3% of annual income would ensure that the costs would remain affordable to the taxpayer and thus no one would be deprived of needed health services. This would also prevent the costs of health care from imposing a catastrophic burden on any taxpayer.

Using survey data on health care utilization rates, Mintz, Aba and Goodman estimated that 62% of Canadians would pay the maximum contribution of 3% of their annual income in any one year. Overall, this would generate $6.6 billion annually in tax revenue (or about 16% of total public spending on physicians, hospitals and other health care institutions). They estimated that it would also lead to a decrease of 13.5% in the use of health services, the value of which they estimated to be $6.3 billion. The authors believe that additional administrative costs would be minimal since the contribution would be collected through the provincial/territorial personal income tax system.

A number of witnesses discussed proposals such as the one by Mintz *et al.*. For example, Paul Darby, Director, Economic Forecasting, Conference Board of Canada, stated:

> *It has a high degree of attractiveness in that it does remove some of the mystery surrounding the cost of health care to various users of the system. It does have the advantage of tying those costs, to some extent at least, to payment. I am not sure it completely gets around the issue of redistribution or the burden perhaps falling on the less advantaged members of society.*[354]

The option of a taxable health care benefit would help ensure visibility. It would also improve somewhat the stability of public health care funding. Such an option would have an impact that in some ways would be similar to direct taxation in terms of efficiency and distortion in the economy. However, it would increase Canada's reliance on the personal income tax, which is already well above that of other OECD countries.

But perhaps most important, the main argument presented to the Committee against a taxable health care benefit is that some people will have the perception that they would be paying for health care twice – once through general taxation and once through the additional income tax they would pay for the specific health services that they would receive during the year. The argument of "double payment" led the Alberta Premier's Advisory Council on Health to decide not to support making health care a taxable benefit.[355]

The Committee was told that a relatively efficient way of generating new federal revenue to pay for health care would be to use some portion of a general consumption tax, such as the GST, and have it earmarked for health care. The GST is the major federal consumption tax in Canada and, according to many witnesses, it is a relatively efficient tax. Because of its broad and generally non-distorting coverage, many witnesses contended that it would be the most suitable consumption tax to increase to pay for additional federal spending on health care.

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[354] Paul Darby (59:17).

[355] Mazankowski report, p. 55.

The GST option, however, would be somewhat more regressive than personal income taxation. Nonetheless, the proposal to earmark an increase in the GST for the purpose of health care received very broad support during the Committee's hearings. For example, Paul Darby explained that:

> *(…) the Conference Board's position on how to address the financing issues over the next 30 years tends towards consumption taxes, such as the GST. We would tend to try to avoid taxes on working, which would include income and payroll taxes. We sense that, at this point, taxes on consumption would probably have the least disincentive effects among the various tax options one could consider. (…) We would want to see a specific link between the taxation and the spending on health care, in the hopes that those taxes would, as a result, be much more politically palatable to the general public.*[356]

Mr. Darby suggested that rebates for low-income Canadians through income tests, such as the current GST Tax Credit, could be provided for an earmarked and increased GST in order to improve equity and progressivity. In addition, if the rebates for the increase in the GST were similar in structure to the current GST rebates, they would add little to the scheme's administrative cost.

15.5 Payroll Taxes

In many OECD countries (such as Germany and the Netherlands), public funding for health care is generated from an earmarked payroll tax. Contributions under this payroll tax are usually compulsory and shared between the employee and the employer. These contributions are levied on labour earnings and are held by a body operating at arm's length from government ("Sickness Funds"). The predominant attraction for earmarked payroll taxes (or "social insurance") in many OECD countries is the independence of the insurer or agency from government and the perceived greater responsiveness of the insurer to the patient or consumer.

In Canada, both the federal and provincial/territorial governments currently use earmarked payroll taxes in one form or another. At the federal level they include: premiums for Employment Insurance and Canada Pension Plan contributions (the CPP/QPP is both a federal and provincial responsibility). Provincial payroll taxes include: workers' compensation premiums (collected in all provinces) and health care/post-secondary education taxes (levied in Quebec, Manitoba, Ontario, Newfoundland and the Northwest Territories), with the latter not generally being firmly dedicated to any specific use.

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[356] *Ibid.*, (59:5).

An earmarked payroll tax as a means of collecting revenue for the purpose of health care has the advantages previously mentioned for earmarked taxes. For example, it can be paid into a separate fund. It is highly visible and transparent and, therefore, usually more acceptable to the public. In other words, higher levels of transparency under a system of payroll taxes weaken resistance to contribution increases compared with general taxation increases. In addition, payroll tax revenue is, at least in theory, better protected from annual political interference, since budgetary and spending decisions can be devolved to independent bodies. Equally important, levying the tax only on labour income avoids distortions to savings and investment. Finally, revenue generated from payroll taxes also appears to be more stable. In this perspective, a recent report states:

> *In Belgium, where health care is financed about equally from taxation and social insurance contributions, the deviation of average annual growth was greater for revenue from government sources than non-government sources. (...) In other words, annual government spending on health care fluctuated more than insurance-based revenue. (...) Consequently, relying more on funding from general taxation than on payroll contributions is likely to make revenue less stable.*[357]

Earmarking a payroll tax, however, has a number of disadvantages. Because employers are usually required to contribute to part of the cost of health care insurance, this results in higher labour costs, inhibits job creation and reduces the international competitiveness of a country's economy. Moreover, a payroll tax relies on a more narrow revenue base (labour earnings). Accordingly, it would require a higher rate of a payroll tax to raise a given amount of revenue than would a general income tax on all income. This may explain why general tax revenue is also used as an important revenue source in countries with health care payroll tax systems. In these countries, general tax funds are usually transferred to health care insurance funds to cover the contributions of the non-employed population. General tax revenues may also cover the deficits of public health care insurance funded by payroll taxes.

In contrast to general taxation, a payroll tax may also impede job mobility; employees may be unwilling to move to a non-covered job (such as self-employment) in some systems for fear of higher contribution payments or fewer benefits (as in the United States).

The potential negative impact of payroll taxes on industry was one of the justifications for diversifying funding sources from an employee/employer contribution system to an income-tax-based system under the Juppé Plan in France. More precisely, France significantly reduced the employee contribution rate (from 5.5% in 1997 to 0.75% in 2000) and dedicated its General Social Contribution Tax specifically to health care (the tax rate was increased from 3.4% to 7.5% of personal income). Italy and Spain went a step further by shifting completely from payroll tax to a general tax-revenue-financed health care system.

Another criticism of payroll taxes with respect to efficiency is that the various European Sickness Funds, which are responsible for collecting and managing the contributions made by employers and employees, have little incentive to control costs because they have the ability to raise contribution rates. Also, the existence in some countries of multiple funds and the lack of integration in purchasing health services often results in high administration costs.

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[357] Mossialos and Dixon (2002), chapter twelve, p. 285.

It could also be argued that health care financing via a payroll tax system is vulnerable to periods of economic downturn, since reduced revenues from lower employment and freezes in income levels would result in smaller contributions to Sickness Funds. Furthermore, with the financing burden concentrated on employers and employees, the negative impacts on certain labour-intensive sectors of the economy could be significant.

Finally, with respect to equity, available evidence from Germany and the Netherlands suggests that funding health care through payroll tax tends to be regressive. This is probably because the design of these two systems allows higher-income earners, who already possess private insurance, to opt out of the public health care insurance plan.

An important element of payroll tax, however, is the smaller impact it has on the overall Canadian economy when compared to other forms of taxation. Preliminary calculations by the Department of Finance showed that an extra dollar of tax revenue raised through payroll taxes cost the economy 27 cents in real loss of output. This is compared to $1.55 in loss of output for every extra dollar of corporate income tax and 56 cents for personal income tax. Sales taxes were shown to be the least distorting source of tax revenue, creating only 17 cents of output loss.[358] In the context of international competitiveness, there is still some room for payroll taxes in Canada: OECD data show that Canada depends less on this form of taxation relative to other industrialized countries.[359]

However, a crucial factor with respect to payroll taxes is that, in terms of intergenerational fairness, payroll tax has an impact similar to but worse then income taxation: the burden is borne entirely by the younger and working population.

15.6 National Health Care Premiums

A public health care insurance premium is a fixed lump-sum amount paid by either an individual or a family for the purpose of financing publicly insured health services. In some systems, health care insurance premiums are fixed amounts paid *regardless* of income and *independent* of usage of the health care system. This form of premium is currently used in both British Columbia and Alberta, although there are some exemptions for low-income individuals and families in the two provinces.

This method of funding is considered to be quite efficient for two reasons. First, the financing burden is spread over a wide base (the entire population) rather than just the employed, as is the case with most payroll taxes. This means that all sectors of the economy are treated equally, and due to the flat nature of premium payments, individuals have little incentive to alter their behaviour (whether to consume more or less, whether to work more or less, etc). Second, health care insurance premiums do not differentiate between the younger and older segments of the population, thereby ensuring inter-generational fairness.

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[358] Department of Finance. Data presented by the OECD, *OECD Economic Surveys – Canada 1997*, November 1997, p. 85.
[359] OECD, *Revenue Statistics 1965-2000*, 2001.

> *Whether a person works or not they would still have to pay the amount. This would be the least distortionary of the types of taxes that could be levied, and the one most conducive to the demographic issues we will face down the road.*[360]

A flat health care insurance premium does not affect marginal income tax rates, as an increase in personal income taxation would, and therefore has a less distorting impact on the economy in terms of savings and investment.

In terms of equity, flat premiums for public health care insurance would tend to hit low-income Canadians the hardest, although some low-income relief could be used to soften that impact. Also, middle-income Canadians would have to pay the same health care premium as rich ones. Therefore flat premiums are clearly regressive, as they benefit most those with high incomes. They do, however, benefit those with high health care needs, since they pay the same amount of premium as those who use the health care system only slightly.

Overall, the equitable characteristics of a system financed by flat premiums appear to be quite limited. The Committee was informed that, for greater equity, premiums should be linked to income in some manner and some groups of the population should be exempted from paying them. The suggestion to use variable premiums adjusted to income levels was recently made in the Mazankowski report, *A Framework for Reform*, prepared for the Premier of Alberta in 2001.

In his brief to the Committee, David Kelly provided a lengthy statement on the benefits of a national health care insurance premium:

> *There may well be need for additional federal revenues to support the Canadian health care system, and a federal health care premium would be one means of raising funds in a fashion which provides visibility for the federal financial contribution.*
>
> *(…) The provincial premiums programs which operate in Alberta and British Columbia raise significant revenue for those provinces. Premiums are fixed amounts applied universally (payment is mandatory), income-related (reduced or eliminated for lower income earners), but unrelated to program eligibility (late or non payment does not result in termination of benefits to an individual or family). Premiums are collected where possible through payroll deduction, with the balance directly billed to provincial residents. The administrative costs of collecting premiums by a process separate from the income tax system are nontrivial.*
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> *(…) Were a federal health care premium to be introduced, it would certainly make sense to collect it through the income tax system, rather than through a separate administrative procedure. That is, one could provide for deduction at source, quarterly payments, and annual reconciliation through the existing tax collection structure, rather than invoicing*

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[360] Jack Mintz (62:7).

> *all Canadian families on a monthly or quarterly basis. There are many potential designs for the structure of a federal premium – it could be a flat rate applied equally to all residents, or a flat rate with relief for lower income earners as in the two provinces which levy their own premiums, or a surtax applied proportionally or in some other fashion on top of the income tax. All these options have their own equity implications. It should be kept in mind that there is a very substantial element of income redistribution associated with the financing of Canada's universal health care program. Any move to finance the system in part through a premium which is less progressive than existing funding sources would affect the nature of that income distribution, and so add to the list of value issues which the Committee must sort through.*[361]

In conclusion, premiums could constitute a visible and equitable means of raising the money for the purpose of health care, provided that they are structured in a way to ensure progressivity (that is, premiums should vary in proportion to income).

15.7 User Charges

User charges are usually defined as a form of payment (covering a portion of the cost of services) made by a patient at the time a health service is rendered. That is, they represent an up-front charge to the patient. In Volume Four of its health care study, the Committee described the different forms of user charges:

- Co-insurance, the simplest form of user charge, requires the patient to pay a fixed percentage (say, 5%) of the cost of services received. Thus, the higher the cost of the service, the larger the fee. Many private-sector drug insurance plans require this method of payment.
- Co-payment is an alternative to co-insurance. Instead of having to pay a share of costs, the patient is required to pay a nominal fee per service (for example $5) which does not necessarily bear any relation to the cost of the service. The same amount is charged, no matter what the cost of the health care provided. This form of user charge exists in many countries, such as Sweden.
- Under a system of deductibles, the patient is required to pay the total costs of services received over a certain period up to a certain ceiling, the deductible. Above the ceiling, costs of services to the patient are covered by the insurance plan. All users must pay the deductible, which is independent of the quantity of services received. Again, this form of insurance-based user charge is required in some countries.[362]

Some commentators have suggested that user charges of relatively modest size can be a useful means of discouraging overuse of the health care system, and of creating some personal sense of responsibility for the use of the system. However, much of the literature with respect to user charges concludes that these charges deter some individuals from seeking necessary as well as unnecessary care, and do so in a way that falls disproportionately on the poor. Professor Robert Evans told the Committee that user charges raise serious issues of access and equity:

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[361] David Kelly, Brief to the Committee, pp. 2-3.

[362] Volume Four, p. 62.

> *It is well-known and extensively documented that a relatively small proportion of the population use a very high proportion of health care services, both in any one time period and over longer times. A recent study in B.C., now being written up for publication, shows that the five percent of the adult population with the highest use of physicians' services (measured in dollars of billings) not only accounted for 33.7% of total billings, but made up 43.5% of hospital admissions and used 69.3% of inpatient days. These people were generally quite ill, typically with major and multiple problems. There were on average older – almost half were over 60 – came from poorer neighbourhoods, and had a death rate nearly eight times that of the general population. For most of them, there seems to be no realistic prospect of their paying over half of the costs that they generate, even if such an extraordinarily skewed distribution of financial burden were acceptable to the general population.*[363]

The Committee reviewed the evidence on user charges in Canada and concluded that access to publicly funded hospitals and doctors should not depend on the income or wealth of individual Canadians.

It is worth noting that Canada is the only industrialized country that prohibits user charges for publicly insured health services. Despite their use elsewhere, the Committee reviewed the evidence on user charges in Canada and concluded in Volume Five that access to publicly funded hospitals and doctors should not depend on the income or wealth of individual Canadians.[364] We explained that most of the spending and waste in the health care system are beyond patient control; the major expenses, and the decisions that give rise to these expenses, are incurred or influenced by health care providers on behalf of their patients. These decisions are not made by the patients themselves. Moreover, the Committee was told that implementing modest user charges could incur administrative costs that would nearly equal the revenue generated from such charges.

For all these reasons, the Committee enunciated in Volume Five Principle Eighteen, which states that while incentives need to be developed to encourage patients to use the hospital and doctor system as efficiently as possible, such incentives should *not* include up-front user charges.

Some form of patient payment, however, could be used in implementing the primary health care reform that the Committee is proposing in Chapter Four. It should not be labelled as a user charge, but rather as an "orientation fee." When primary health care physicians make referrals to specialists, patients do not incur any costs. Should the patient decide to take an appointment to a medical specialist without any referral, he or she should be liable for part or all of the cost incurred by this visit. This form of patient payment is required in Denmark.

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[363] Robert Evans, Brief to the Committee, 3 June 2002, p. 6.

[364] Volume Five, pp. 53-54.

15.8 Medical Savings Accounts

As described in Volume Three of the Committee's study on health care, Medical Savings Accounts (MSAs) are health care accounts, similar to bank accounts, set up to pay for the health care expenses of an individual (or family).[365] They are often established in conjunction with high-deductible (or catastrophic) health care insurance. Money contributed to an MSA belongs to, and is controlled by, the account holder, accumulates on a tax-free basis and is not taxed if used for health care purposes. Unused MSA funds can be utilized for other purposes to the benefit of the account holder.

MSAs usually involves three levels of payment. First, money in the account is used for normal medical expenses. Next, if the account is exhausted and the deductible has not been reached, the user pays the expenses personally. Third, public health care insurance covers expenses beyond the deductible.

MSA systems are operating in a few jurisdictions, including Singapore, South Africa and parts of the United States. The general theory behind MSAs is that consumers would make more judicious and cost-effective decisions if they were spending their own money, rather than relying on the "free" publicly funded services. As a result, MSAs would limit (if not eliminate) unnecessary utilization of health services, reduce the pressures on public health care funding and encourage efficiency.

A number of proposals for MSAs have been put forward in recent years in Canada.[366] Given the interest of a number of Canadians in MSAs, the Committee reviewed the literature on the topic and held discussions with various individuals and experts. Based on the evidence received, we believe that, although MSAs have some interesting elements, they would not be appropriate in our publicly funded hospital and doctor system.

First, there is no consensus among experts on the impact of MSAs on a country's health status and overall health care costs. On the one hand, some maintain that MSAs increase consumer choice, encourage patients to make more prudent use of health services and reduce health care spending. On the other hand, others contend that MSAs can realize only small health care savings at best, segment the risk in the insurance market, drive up costs and have an adverse impact on health as people, particularly the poor and unhealthy, cut back on necessary health care. Moreover, the most recent literature suggests that current knowledge of MSAs is too limited to recommend their incorporation into the Canadian health care system.[367]

However, the impact on equity is certainly the aspect that is of most concern to the Committee. Like user charges, MSAs transfer part of the responsibility for health care spending from government directly to patients. Furthermore, they do so in a manner that falls disproportionately on the poor and on those who are sick, whether rich or poor. In fact, MSAs reduce the subsidy that the well now pay to the poor. A recent study reports that, if MSAs were implemented in Manitoba for hospitals and physician services, then the sickest 20% of residents in that province would become personally responsible for over $60 million of health care costs.[368]

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[365] Volume Three, Chapter Seven, pp. 53-63.

[366] See the following documents: 1) William McArthur, Cynthia Ramsay and Michael Walker ed., *Healthy Incentives: Canadian Health Reform in a Canadian Context*, The Fraser Institute, 1996; 2) Cynthia Ramsay, "Medical Savings Accounts", *Critical Issues Bulletin*, The Fraser Institute, 1998; 3) David Gratzer, *Code Blue – Reviving Canada's Health Care System*, ECW Press, 1999; 4) Dennis Owens and Peter Holle, *Universal Medical Savings Accounts*, Frontier Centre for Public Policy, Policy Series No. 5, July 2000.

[367] Samuel E.D. Shortt, "Medical Savings Accounts in Publicly Funded Health Care Systems: Enthusiasm versus Evidence", in *Canadian Medical Association Journal*, Vol. 167, No. 2, 23 July 2002, pp. 159-162.

In Volume Four, the Committee indicated that a system of MSAs might be contemplated for application in a limited sphere, such as paying for long-term care facilities, where there are already significant private out-of-pocket charges. However, MSAs should *not* be applied in the broader health care field involving presently insured services.

Therefore, the Committee strongly believes that funding for medically required hospital care and physician services must remain the responsibility of a publicly funded and administered health care insurance program. This is consistent with Principle Four in our Volume Five, which stated: "Health services covered under the *Canada Health Act* should remain publicly insured. Other health services should continue to be funded using a mix of public and private sources, as they are now."[369]

The Committee strongly believes that funding for medically required hospital care and physician services must remain the responsibility of a publicly funded and administered health care insurance program.

15.9 Pre-Funding for Health Care

In the context of an aging population, the option of pre-funding health care is gaining some popularity. Pre-funding involves setting aside funds today to meet all or part of projected future cost increases in health care, so as to enable Canada to maintain a relatively stable (or at least more stable) annual ratio of health care spending to GDP. Excess revenues gathered now for such pre-funding would be placed in a special account, to be made available later for stabilization purposes.

Unfortunately, the costs of full pre-funding are high, even when the stabilization is attempted over a period of 30-40 years during which Canada's population will be getting significantly older. Accordingly, there may not be the popular will to implement a long term pre-funding plan now when the need to meet immediate cost pressures in the system is seen to be urgent. And the question could be raised, as with earmarked taxation, as to why health care costs only should be pre-funded – what about other costs that will also vary with aging of the population?

It has been suggested that it may be more practical to consider the pre-funding of only some elements of overall health care costs, specifically those relating to health services for the elderly, such as home and institutional care, that are not now publicly funded. Such pre-funding might be accomplished through a government plan financed by current taxation or through private health care insurance coverage. Such a scheme (comparable to MSAs) would assist individuals to save for future health care costs on a tax-efficient basis, especially if the premiums are deductible and earnings on accumulated funds are exempt from tax. Ultimately, pre-funding would relieve the publicly funded health care system of some costs that it now incurs in subsidizing some of those who need such services.

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[368] Evelyn L. Forget, Raisa Deber and Leslie L. Roos, "Medical Savings Accounts: Will They Reduce Costs?", in *Canadian Medical Association Journal*, Vol. 167, No. 2, 23 July 2002, pp. 143-147.
[369] Volume Five, p. 30.

A variant of this approach was proposed by the Clair Commission in Quebec, which recommended that a separately managed fund be established to pre-fund the costs of both home and institutional care for individuals no longer able to care for themselves. The Commission recommended that the fund be financed by a mandatory premium (tax) on personal income from all sources, and be for the benefit of those (particularly the elderly) whose inability to care for themselves was long-term (over six months). Such a plan would provide an improvement in and integration of existing services for long-term disability and yet avoid a rapid rise in health care costs for an aging population.

This approach has a number of advantages: its financing structure is highly visible and the funds generated are wholly dedicated. The degree of equity of this funding method, as well as its impact on efficiency and intergenerational fairness, would depend on the source of revenue used to raise the money – personal income tax, public premiums or private health care insurance.

Given that the need to raise additional revenue to fund health care is urgent, the Committee does not endorse pre-funding. In our view, it would be very difficult to justify setting aside funds for future needs while substantial sums of money are required now throughout the publicly funded health care system to undertake its restructuring, renewal and expansion.

15.10 Committee Commentary[370]

Sections 15.3 to 15.9 above have described a wide variety of possible options for raising $5 billion annually in new federal government revenue; they have also presented in some detail the advantages and disadvantages associated with each option in terms of five specific criteria – equity, efficiency, intergenerational fairness, stability and visibility. On the basis of this information, the Committee reached conclusions about the approaches it favours.

We wish to say, up front, that there is no such thing as a "good" tax. There are, however, specific objectives that a new tax or revenue-generating initiative designed to pay for a specific public benefit should meet:

- The tax should be apportioned fairly and reasonably over the groups that will be called upon to pay it;
- The tax should have the least possible adverse effect on economic activity and growth in relation to the revenues raised;
- The tax should involve modest administrative costs of compliance for taxpayers and collection costs to government;

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[370] The Committee is indebted to Robert D. Brown, former chairman of Price Waterhouse, and his research assistant Michanne Haynes, for many of the calculations and revenue estimates presented in this chapter. The assistance of the Department of Finance in supplying statistical data is gratefully acknowledged.

- The justification for the tax should be clearly apparent to the public, preferably by associating the revenue directly with the benefits of the spending;
- The tax should produce revenues that are stable and robust (in the sense that they will grow at about the rate of GDP), enabling the funds raised to meet increasing costs in the future;
- To justify its collection, the tax should be perceived to result in some tangible improvements to the system and to health care coverage.

On balance, the evidence available on how different revenue sources affect equity shows that equity is best served when health care is funded through personal income taxation or consumption taxes, rather than through payroll taxes or fixed premiums. In addition, from an efficiency viewpoint, international experience indicates that payroll taxation may affect the labour market more negatively than general taxation, because contributions are levied only on wages and employers are liable for part of the contribution. Finally, research shows that, whatever the method of raising revenue, the level of economic activity at any given time significantly influences the ability of a country to raise money for health care (or for any other purpose). Moreover, spending on health care has an opportunity cost, and other sectors may take priority in times of economic contraction or military conflict.

However, a major advantage of both payroll taxation and premiums over existing income and other general taxation is that they are more visible, transparent and predictable sources of financing. Earmarked taxation would certainly help in bringing more visibility, and possibly even greater stability, to a tax-funded health care system.

The Committee is of the view that increased federal revenue for hospital and doctor services should not come disproportionately from those who are ill. These services are now perceived to be "free." The method of raising revenue should not be perceived as a "tax on the sick." For this reason, the Committee rejects all forms of financing that call for individuals to pay directly on the basis of their utilization of the hospital and doctor system.

The Committee is of the view that increased federal revenue for hospital and doctor services should not come disproportionately from those who are ill. The method of raising revenue should not be perceived as a "tax on the sick."

Furthermore, the Committee believes that the increased federal revenue should be raised based on ability to pay; that is, to ensure equity, individuals with higher incomes should pay more than individuals with lower incomes. For this reason, the Committee rejects the option of a flat national health care insurance premium. But, as we discuss below, we are not opposed to the option of a progressive health care insurance premium structure.

With respect to direct taxation, calculations done on behalf of the Committee by Brown and Haynes indicate that it would be necessary to increase the rate applicable to each taxable income bracket of personal income tax by 1.1 percentage points in order to raise $5 billion in additional federal revenue. Another way to finance an incremental annual federal spending on health care through the personal income tax would be to impose a 5.7% surtax on all federal tax. The Committee was told that these two options would, however, reverse approximately one-third of the 2000 federal personal tax cuts provided under the five-year tax plan and raise marginal tax rates significantly.

Calculations by Brown and Haynes also indicate that it would be necessary to increase the general rate of corporate tax by 7 percentage points in order to raise an additional $5 billion in federal revenue. This would, however, reverse all present and scheduled future cuts in corporate tax, leaving Canada's rates uncompetitive internationally. This would, therefore, severely affect the Canadian business sector, employment and the overall economy.

The Committee is convinced that the changes to the Canadian tax structure that lead to increased revenue should be done in a way that keeps Canada's tax rates, including personal income tax rates, relatively competitive with other OECD countries, particularly the United States. In addition, for the sake of intergenerational fairness, we believe that the working population should not bear a disproportionate burden of taxation relative to the retired population. For these reasons, and based on the estimates given above, the Committee rejects the option of raising funds by increasing personal income taxes or corporate income taxes.

Although there appears to be some room for a payroll tax from an international competitiveness perspective, the Committee rejects this option on the grounds of intergenerational fairness. It would be unfair to require one segment of the population – working Canadians – to bear the costs of increased investment in the publicly funded health care system. This is particularly true in the context of an aging population with a reducing proportion of that population in the workforce.

It is the view of the Committee that it would be unfair to require one segment of the population –working Canadians – to bear the costs of increased investment in the publicly funded health care system. This is particularly true in the context of an aging population.

Therefore, the Committee concludes that there are two possible ways in which $5 billion could be raised annually from Canadians and which comply with the set of criteria and objectives listed above. The first option is a *National Health Care Sales Tax*. The testimony received by the Committee suggests that, although this option might be considered mildly regressive, the benefits gained from an efficiency point of view far outweigh the impact on equity. In addition, expanded tax credit rebates would greatly reduce the impact of sales tax on lower-income people. The tax would be collected using the same base as the Goods and Services Tax (GST) so that its collection would be straightforward. Calculations done for the Committee suggest that the rate of tax required to raise $5 billion annually would be around 1.5% (precisely, 1.3%). Thus, under the National Health Care Sales Tax option, Canadians would pay a national sales tax of 8.5%, which would consist of a 7% GST and a 1.5% National Health Care Sales Tax. The GST tax credit rebate program would be expanded to parallel the increase in the rate to 8.5%.

The second option involves a *Variable National Health Care Insurance Premium*. Under this option, Canadians would pay, through the tax system, a national health care insurance premium the amount of which would vary with the individual's taxable income as shown in Table 15.3. For each taxable income bracket currently used for the purpose of calculating an individual's federal personal income tax, a flat premium would be charged. The premium would then increase (indeed double) for individuals in the following income bracket.

TABLE 15.3
ANNUAL FEDERAL REVENUE GENERATED FROM A VARIABLE NATIONAL HEALTH CARE INSURANCE PREMIUM

Taxable Income Bracket (Federal Personal Income Tax Rate)	Number of Taxfilers Paying Premiums (Millions)	Level of Premium (Dollars)	Estimated Annual Federal Revenue ($ Billion)
Up to $31,677 (16%)	7.9	**$0.50/day (or $185/year)**	1.341
$31,678 to $63,354 (22%)	5.8	**$1/day (or $370/year)**	2.096
$63,355 to $103,000 (26%)	1.4	**$2/day (or $740/year)**	0.968
Over $103,000 (29%)	0.5	**$4/day (or $1,400/year)**	0.622
ESTIMATED TOTAL FEDERAL REVENUE			**5.027**

1. Taxfilers in the taxable income bracket from $0 to $31,677 with no net federal tax liability (net of non-refundable tax credits) will not be liable for any health care premium.
2. In addition, taxfilers in this first bracket who do have net federal tax will pay the lesser of $185 or 10% of taxable income not offset by the income equivalent to the amount of the non-refundable tax credits. This provision is designed to prevent the premium payable by taxpayers in this bracket with only modest net federal tax from being disproportionate to their income tax. For example, suppose that a taxfiler has a taxable income of $9,934. The federal tax on this taxable income is 16%, which amounts to $1,590. But this taxfiler also has $9,000 on which he/she can claim the 16% of non-refundable tax credits or $1,440. Thus, the net federal tax for this taxfiler is $150 ($1,590 minus $1,440). For taxfilers in this income bracket, the premium corresponds to 10% of the value obtained from the difference between the taxable income (e.g. $9,934) and the amounts on which the non-refundable tax credits are claimed (e.g. $9,000). The taxfiler in the above example has a $150 net federal tax from taxable income of $934 in excess of the amounts on which the refundable tax credits are calculated; this taxfiler would thus pay a premium of $93.40 (that is, 10% of $934) instead of $185, the normal premium for this bracket.
3. There is a total of 15.4 million taxfilers with income less than $31,677 of whom only 7.9 million pay net federal tax. The average premium for all taxfilers in this bracket is $71. For the 7.9 million with net federal tax, the average premium is $170.
4. Individual taxfilers in the 22%, 26% and 29% brackets are subject to "notch relief", so that their premium will not be more than the premium for the income bracket below theirs, plus 10% of their income exceeding the bracket threshold. This provision is designed to prevent a taxpayer who receives income that puts him/her just over the bottom of the next income bracket from facing an abrupt and steep increase in premium. For example, an individual with income of $33,177 ($1,500 in excess of the 22% bracket threshold of $31,677) would pay $185 (the premium of the previous bracket) plus $150 ($1,500 times 10%) for a total premium of $335, instead of the normal premium of $370 for this bracket.
5. Calculation based on 2001-2002 data.

Source: Robert D. Brown and Michanne Haynes. Based on data provided by the Department of Finance.

To ensure that individuals with taxable income only slightly in excess of the bottom of their bracket are not subject to a significant increase in their premiums, a "notch relief" provision has been incorporated into the calculation of premiums. This notch relief provides that the premiums of taxpayers will not be more than the premium of the income bracket below theirs plus 10% of income exceeding the income threshold for the bracket. Thus, the Variable National Health Care Insurance Premium is progressive across the entire income spectrum, but it is virtually flat within each income bracket.[371]

Although the Variable National Health Care Insurance Premium would be calculated through the income tax, it is *not* equivalent to an increase in personal income tax. The premium has some aspects of an income tax (because it is subject to some variation in incomes), but in fact it basically varies by taxable income bracket, not income. Moreover, the premium would have only a very moderate impact on marginal income tax rates, which would rise only at the "notch points" where the higher premium in the next bracket is phased in. Therefore, marginal rates would be relatively unchanged and, accordingly, would have much less impact on personal incentives to earn, save and invest than that which would result from an increase in personal income taxation.

The Committee understands that it is up to the federal government to decide which of the two options, either a National Health Care Sales Tax *or* a Variable National Health Care Insurance Premium, is most appropriate to raise the needed $5 billion annually. Both options for raising $5 billion annually in new federal health care revenue have advantages and disadvantages.

Both options for raising $5 billion annually in new federal health care revenue have advantages and disadvantages.

On the one hand, the National Health Care Sales Tax would be simple to administer, as it would be based on the identical tax base to the GST. In addition, this option has a built-in growth factor, as sales tax revenue grows with the economy. Since health care spending is forecast to grow at a rate faster than the growth in GDP, having a built-in growth factor is important. Moreover, the National Health Care Sales Tax would not be significantly regressive, particularly since the GST tax credit rebate program would be extended to the new tax. Nonetheless, a major barrier to any sales tax increase is strong public opposition to such taxes in general, and the GST in particular.

The most important issue is for Canadians to agree to contribute $5 billion annually in new federal revenue for health care.

On the other hand, the Variable National Health Care Insurance Premium has the advantage of being progressive as the amount of premium increases, in stages, with income. Such a national premium would also be consistent with the way in which individuals usually buy insurance, namely by paying for it through an annual premium. However, the premium option has the significant disadvantage that the more steps there are in the premium structure, the closer the premium is to an income tax increase and, for reasons stated earlier in this chapter, the Committee is opposed to an income tax increase. Moreover, the fewer steps there are in the premium structure (hence the less it looks like an income tax), the more regressive this option becomes.

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[371] As indicated in Section 15.4, the Committee rejects the option of a flat annual health care premium because it is clearly regressive. For example, calculations indicate that it would require an annual flat premium of $425 for every taxfiler with income over $20,000 to generate $5 billion in revenue. But there are over 136,000 taxfilers who have income in excess of $20,000 and who pay no tax because of the application of credits such as the Charitable Donation Credit. For this group, the payment of a flat premium would be a significant additional burden. If the flat rate premium were modified so that it could not exceed 5% of taxable income in excess of the $20,000 threshold, then the required annual premium would increase to $500, and there would still be some taxfilers with no net tax who would be required to pay some of the premium.

From the Committee's perspective, the most important issue is for Canadians to agree to contribute $5 billion annually in new federal revenue for health care. This is the issue Canadians need to seriously consider, debate and then decide.

Which of the two options described above is eventually chosen as the revenue raising mechanism is less important than agreement to raise the $5 billion. Nevertheless, in choosing between the two options, the Committee recommends the National Variable Health Care Insurance Premium. Therefore, the Committee recommends that:

In choosing between the two options, the Committee recommends the National Variable Health Care Insurance Premium.

The federal government establish a National Variable Health Care Insurance Premium in order to raise the necessary federal revenue to finance implementation of the Committee's recommendations.

15.11 Current Federal Funding for Health Care

The Committee recognizes that the $5 billion in increased spending is not the entire increase in federal health care spending that will be required in the years ahead. The cost of the hospital and doctor system to which the federal government now contributes will continue to grow. The increased revenues required to cover these increasing costs will have to be funded out of the efficiency savings that result from the restructuring recommendations proposed in this report, and from the general growth in federal revenues from existing tax sources.

In order to substantially improve transparency and accountability in federal health care spending, the 62% of federal CHST cash transfers which are currently notionally attributed to health care ought to be paid for through an earmarked tax source.

This raises the question of whether, in order to substantially improve transparency and accountability in federal health care spending, the 62% of federal CHST cash transfers that are currently notionally attributed to health care (according to Finance Canada's estimation) ought to be paid for through an *earmarked* tax source (as described in Section 15.4 above). This would help the public considerably in understanding how much federal money is spent on health care. Canadians would thus see a more direct link between the taxes they pay and the health services they receive. It would also greatly help to dispel the widely held perception that health care is "free."

One way to do this would be to earmark some of the seven percentage points of the GST to health care. Calculations done for the Committee indicate that it would be necessary to earmark 3.1 of the 7 percentage points of the GST (or around 45% of the revenue generated through the GST) to obtain the 62% of current federal CHST cash transfers which are related to health care.

However, given the need for an increase in the current CHST funding (at least until the full impact of the Committee's restructuring recommendations come into effect), it is probably appropriate that, if an earmarked source is to be used for the current federal cash contribution to health care, and if the earmarked source is to be the GST, then 3.5 (rather than the calculated current 3.1) of the 7 percentage points of GST revenue (or 50% of GST revenue) should be earmarked for health care. This would increase federal base funding for health care by $1.5 billion. In addition, transparency would be enormously enhanced by earmarking half of GST revenue to be the federal cash contribution to health care, supplemented by the additional funding required for implementation of the reforms recommended in this report.

A significant advantage of using the GST revenue as the earmarked source is that it has a built-in escalator: as the economy goes, so does the GST revenue. Thus, using 3.5 of the 7 percentage points of the GST (rather than the calculated current 3.1 percentage points) to fund the federal cash contribution to the existing publicly funded hospital and doctor system would create the stable and predictable source of federal funding that the Committee called for in Principle Two in Volume Five[372] as well as lead to augmentation of this federal contribution. Therefore, the Committee recommends that:

Using 3.5 of the 7 percentage points of the GST (rather than the calculated current 3.1 percentage points) to fund the cash federal contribution to the existing publicly funded hospital and doctor system would both create the stable and predictable source of federal funding the Committee called for in Principle Two in Volume Five as well as lead to augmentation of this federal contribution.

> **The federal government determine an earmarked revenue source which would fund the approximately 62% of CHST currently regarded as being the federal annual cash contribution to Canada's national health care insurance program.**

If the GST is chosen as the earmarked revenue source for the current federal annual cash contribution to the national hospital and doctor insurance program, 3.1 of the 7 percentage points of the GST would be required to meet the current funding levels. In this case, the Committee further recommends that:

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[372] Volume Five, pp. 25-28.

If the GST is chosen as the earmarked revenue source for the current federal cash contribution to the national hospital and doctor insurance plan, then in order for the federal government to make a significant additional contribution to funding to the current hospital and doctor system, half of all GST revenue (or 3.5 of the 7 percentage points) should be earmarked for health care. (This would be in addition to the increased federal funding required to implement the recommendations in this report.)

If the above two recommendations are accepted, then the federal government would be indirectly contributing *at least* an additional $3.0 billion a year to the *existing* public hospital and doctor insurance program. $1.5 billion would come from increasing to 3.5 percentage points the amount of GST revenue earmarked for health care, while another $1.5 billion would, as discussed in Section 15.1, come from money that the provinces are now spending and that they would no longer have to spend once the recommendations in this report are implemented. This amount would then be reinvested in the existing health care system.

If the federal government also decided to invest the $1-billion contingency (as discussed in Section 15.1) as a transitional payment into the existing hospital and doctor system while the efficiency measures proposed in this report are being put into effect, the total additional contribution of the federal government to the *existing* system would be *at least* $4 billion.

The Committee believes it is important to acknowledge the fact that the health care costs of the elderly are considerably higher than the health care costs of younger people, and that some provinces have a higher percentage of their population aged 70 and over than other provinces.

Finally, CHST transfers are currently distributed to the provinces/territories on a per capita basis. If the health care portion of the CHST is paid from an earmarked revenue source as recommended above, the Committee believes that a variation should be made to the way a province's share of the fund is determined. More precisely, we believe it is important to acknowledge the fact that the health care costs of the elderly are considerably higher than the health care costs of younger people, and that some provinces have a much higher percentage of their population aged 70 and over than other provinces. Accordingly, the Committee recommends that:

The share of the federal annual contribution to which a province/territory is entitled for the purpose of the existing national hospital and doctor program be not only based on the proportion of its population relative to Canada as a whole, but also weighted in some way by the percentage of its population aged 70 years and over.

A variety of weighting formulae are possible, and should be explored in order to improve the fairness of current federal health care contributions to the provinces and territories. However, a simple formula would be to give triple the weight to each provincial resident aged 70 years and over. This would be of significant assistance to smaller provinces while not significantly hurting wealthier ones.

CHAPTER SIXTEEN

THE CONSEQUENCES OF NOT MAKING THE HEALTH CARE SYSTEM FISCALLY SUSTAINABLE

The previous chapter detailed the Committee's position with respect to how additional federal revenue should be raised and administered in order to implement our recommendations. We believe strongly that their implementation is essential if health care reform and renewal is to be undertaken, and if this is to be done in a manner that is effective, transparent and accountable. The Committee is convinced that an additional $5 billion annually must be invested by the federal government to finance the changes necessary to secure a high-quality and fiscally sustainable health care system.

The Committee also realizes, however, that in a free and democratic society, Canadians may not be willing to pay more taxes to the federal government (through the National Health Care Insurance Premium as we recommend in this report) to support their national health care insurance system – Medicare. Conversely, the federal government may be unwilling to impose a tax increase on a reluctant population, even though the increased revenue would be spent on health care. In this case, the question then arises as to what the consequences would be. They would include the following:

The Committee also realizes, however, that in a free and democratic society, Canadians may not be willing to pay more taxes to the federal government (through the National Health Care Insurance Premium as we recommend in this report) to support their national health care insurance system – Medicare. Conversely, the federal government may be unwilling to impose a tax increase on a reluctant population, even though the increased revenue would be spent on health care.

- No proposed expansion of public health care insurance coverage to include catastrophic prescription drug costs, some post hospital home care treatment and out-of-hospital palliative care would occur;
- No reform and renewal of the hospital and doctor system would take place and major health care cost pressures would continue to erode the system;
- Nor would the essential investments in infrastructure occur, particularly those in health information management, health care technology and expanded enrolment in medical and nursing schools;
- This, in turn, would make implementation of the National Health Care Guarantee impossible. Given Canada's relative deficiency in medical equipment and health care providers to deal with waiting queues, understandably provincial governments would be unwilling to legislate a care guarantee if its implementation meant they would have to pay the cost of sending an ever increasing number of patients to the United States or elsewhere for treatment;

- A Canadian health infostructure, along with the full deployment of a system of electronic health records and a system of service-based funding for hospitals, would not be developed, thus limiting Canada's ability to evaluate the cost, effectiveness, quality, performance and outcomes of its health care system or to develop strategies to increase its productivity.

In short, in the absence of the additional investment the Committee recommends, the Canadian health care system will continue to deteriorate. The "health care contract"[373] between Canadians and their governments will break if Canadians are unwilling to pay an additional $5 billion in taxes (the citizens' part of the contract) so that government can finance adequately the changes necessary for the sustainability of our publicly funded, universal, comprehensive, accessible and portable hospital and doctor insurance plan (the government part of the contract), expanded to cover, in part, out-of-hospital prescription drugs, home care and palliative care as recommended.

Under these circumstances, it seems highly probable that, for the reasons discussed in Chapter Five, the courts would decide that under the *Charter of Rights and Freedoms*, government could no longer deny Canadians the right to purchase private health care insurance that would enable them to receive and pay for health services in Canada that are also included in the publicly insured set of services. Thus, a parallel private health care system is likely to emerge.

***The Committee has stated on numerous occasions, and we repeat it here again, that we are in favour of a single public funder/insurer for hospital and doctor services covered under the* Canada Health Act.**

This is ***not*** the outcome preferred by the Committee. We have stated on numerous occasions, and we repeat it here again, that we are in favour of a single public funder/insurer for hospital and doctor services covered under the *Canada Health Act*. The single, public insurer model was, in fact, the first principle enunciated in Volume Five.[374] As a corollary, private insurance for publicly insured health services should continue to be disallowed, ***provided*** that such publicly insured services are delivered in a ***timely*** fashion.

Nonetheless, the Committee believes it is important to consider the implications of allowing private health care insurance to develop, together with its associated parallel privately funded hospital and doctor system. This is the purpose of this chapter. Section 16.1 describes briefly the role of private health care insurance in Canada and in selected OECD countries. Section 16.2 provides a summary of the findings of recent literature on the impact of private health care insurance on costs, access and quality in the publicly funded health care system. Finally, Section 16.3 sets out the Committee's view on the possible development of a parallel private delivery system in Canada.

It is the view of the Committee that private insurance for publicly insured health services should continue to be disallowed, provided that such services are delivered in a* timely *fashion.

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[373] Volume Five, p. 61.

[374] Volume Five, pp. 23-25.

16.1 Private Health Care Insurance in Canada and Selected OECD Countries

Currently, the *Canada Health Act* requires public health care insurance plans to be accountable to the provincial government and to be not-for-profit. Moreover, the majority of provinces (Alberta, British Columbia, Manitoba, Ontario, Prince Edward Island and Quebec) prohibit private companies from insuring services that are covered under public health care insurance plans.[375] In these provinces, private insurers are limited to providing supplementary health care benefits, such as semi-private or private accommodation during hospital stay, prescription drugs, dental care and eyeglasses – all services that are not insured under provincial health care insurance plans.

Four provinces do permit private health care insurance for services that are also publicly insured (New Brunswick, Newfoundland, Nova Scotia and Saskatchewan). Thus, patients of opted-out physicians[376] in these provinces can substitute private for public health care coverage. However, provincial legislation that prohibits opted-out physicians from practising both in the publicly funded system and privately has meant that few opt out. Therefore, few people purchase private health care insurance.

For example, in Nova Scotia, opted-out physicians cannot bill privately in excess of the fee specified on the public insurance fee schedule. This creates a disincentive, as physicians cannot be paid more for equivalent cases working under private insurance than if they worked within the public plan. As a result, there are very few opted-out physicians and, consequently, there is little need for private health care insurance to cover publicly insured health services.

In Newfoundland, patients of opted-out physicians are entitled to public coverage up to the amount set out in the fee schedule (in other words, patients are entitled to public funds to subsidize the cost of buying their health services in the private for-profit sector). Out-of-pocket spending by patients is thus limited to the difference between the fee charged by the opted-out physician and the publicly scheduled fee; but few physicians have opted out in Newfoundland and, therefore, there is little demand for private health care insurance.

In New Brunswick and Saskatchewan, patients of opted-out physicians cannot be subsidized by the public plan as they would be in Newfoundland. Nonetheless, there has been no significant development of private-sector in health care insurance in these two provinces.

Overall, the *Canada Health Act*, together with provincial/territorial legislation, has prevented the emergence of private health care insurance in Canada that competes directly with public insurance. It is simply not economically feasible for patients, physicians or health care institutions to participate in a private parallel system.

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[375] Colleen M. Flood and Tom Archibald, "The Illegality of Private Health Care in Canada", in *Canadian Medical Association Journal*, Vol. 164, No. 6, 20 March 2001, pp. 825-830.

[376] A physician opts out when he/she chooses to give up his/her rights to bill the public health care insurance plan and takes up practice in the private sector. Every provincial health care insurance legislation permits physicians to opt out.

This contrasts sharply with the situation in other OECD countries, in which private health care insurance can and does compete with public health care insurance, and physicians can work in and receive payments from both the public and the private sectors.[377] There are two different models of private insurance for health services in these countries. The first, prevalent in Germany and the Netherlands, involves a system of private insurance and service delivery that is totally separate from the public system. The second, in place in countries like Australia, Sweden and the United Kingdom, involves competition between public and private insurers and interaction between public and private providers.

In Germany and the Netherlands, private health care insurance is voluntary for those people with relatively high annual incomes (while public coverage is mandatory for those with middle and lower incomes). The private insurers must accept all those who apply for coverage and must provide benefits equivalent to those offered under the public plan. Thus, private insurers cannot "cherry-pick," i.e., restrict coverage to patients who are healthy and wealthy, thereby leaving the public sector to pay for patients who are less healthy and wealthy. The premiums paid for private insurance are risk-related (but subject to strict regulation) and do not vary significantly for equivalent coverage.

In the United Kingdom, residents can purchase private insurance to cover the same health services provided in private hospitals as are offered in public hospitals. Although privately-insured patients in the United Kingdom usually obtain their health services outside the NHS; they can also be treated in NHS facilities in which "pay beds" are available. Physicians are permitted to earn up to 10% of their gross annual income from private practice.

In Australia, private health care insurance, as in the United Kingdom, competes with the public plan. Moreover, the Australian government actively encourages residents to acquire private health care insurance by subsidizing 30% of its cost. Premiums required under private health care insurance are strictly regulated and community-rated (i.e., a single premium applies to everyone, regardless of his/her health status). Privately insured patients may receive care in either a public or private hospital; in both cases, the public health care insurance plan subsidizes 75% of the hospital costs, while the remainder is covered by private insurance. Specialists working in public hospitals can treat patients privately and receive payment both from private and public health care insurance plans.

Private health care insurance is permitted even in Sweden, which is generally recognized as being amongst the most socialized of European countries. In Sweden, as in Australia, government legislation requires that premiums charged by private health care insurers must be community-rated. Private hospitals do not usually obtain payment from the publicly funded plan, unless care is provided through contracts with the county councils.[378] Physicians in Sweden are allowed to work in both the public and the private sectors.

The evidence summarized in the Committee's Volume Three, as well as the findings of a Canadian study,[379] show that the vast majority of care delivered in private for-profit health care institutions in countries like Australia, New Zealand, the Netherlands, Sweden and the United Kingdom is funded through private health care insurance. Also, physicians practising in those countries are usually employed in the public sector and top up their incomes by working in the private sector on a fee-for-service basis. It should be noted, however, that in all these countries the private for-profit sector is quite small.

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[377] For more information on health care systems elsewhere, consult the Committee's Volume Three.

[378] This, in fact, is becoming more prevalent in Scandinavian countries under their new health care guarantee.

[379] Cam Donaldson and Gillian Currie, *The Public Purchase of Private Surgical Services: A Systematic Review of the Evidence on Efficiency and Equity*, Institute of Health Economics (Alberta), Working Paper 00-9, 2000.

The restriction on the role of private health care insurance in Canada as well as on physician opted-out practice is unique among OECD countries. Pressures to loosen the restrictions and create a parallel system of private insurance and delivery will increase, however, if timely access to needed services cannot be assured in the publicly funded health care system. This observation was already noted in 1996 by Glouberman and Vining when they stated that:

> *It is obvious that any significant initiatives (whether implicit or explicit) to further ration publicly-financed health care will encourage increased demand for privately-financed health care.*[380]

Jeffrey Lozon, President of St. Michael's Hospital in Toronto and former Deputy Minister of Health in Ontario, put this question to the Committee:

> *When you take the notions of a private insurance system (…) out of the discussion, you are left inevitably with the question of tax increases, whether dedicated or not. I would like to raise this: Why not allow individuals to purchase health insurance that would provide them with another level of care (…)? Why not allow individuals who have the wherewithal to say, "I do not want to have to wait six months for my hip replacement", to buy that service?*[381]

16.2 Review of Recent Literature on the Impact of Private Health Care Insurance and Private For-Profit Delivery

Advocates for a parallel private system argue that it will ensure the sustainability of the publicly funded system (by reducing public cost pressures), improve access to the public system (by reducing waiting times), and improve quality in the public system (through competition). They also argue that private health care insurance would give patients access to greater choice and higher-quality services without compromising the public system.

By contrast, opponents of a parallel private system contend that it will create "two-tier" health care, compromise equity, increase costs, and reduce quality and access to the publicly financed system, as those who have the financial means to purchase private insurance exit to private delivery institutions. They also argue that, with higher pay-per-unit activity in the privately funded system, personnel is likely to be drawn from the public system, making waiting times longer in the public system in the absence of an adequate supply of doctors and nurses. Moreover, they contend that the private for-profit sector "cherry picks" the relatively routine, uncomplicated (and therefore less expensive) care – elective surgery and the like – and leaves to the public system the complex, emergency and more expensive services, thereby increasing substantially the unit costs of the public system.

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[380] Steven Glouberman and Aidan Vining, *Cure or Disease? Private Health Insurance in Canada*, University of Toronto, 1996, p. 61.

[381] Jeffrey Lozon (53:64).

The Committee believes that the truth lies between those two extreme views. What does the international evidence suggest? A review of recent literature on the subject of private health care insurance and delivery indicates the following:[382]

- In the United Kingdom (as in New Zealand), private health care insurance has encouraged the development of private health care delivery. In both countries, physicians can work in the public as well as the private sector; physicians are usually employed in the public sector and top up their incomes by working in the private sector on a fee-for-service basis.
- In the United Kingdom (as in Germany and the Netherlands), private health care insurers pay much more than does public insurance for the same health service. For example, physicians can earn three to four times more in the private sector than in the National Health Service (NHS) for providing the same service.
- Private hospitals are well established in the United Kingdom and are regularly used by the NHS to pick up excess demand when public sector waiting times get too long (just as some provincial governments use the American private health care sector to relieve queues in Canada).
- Patients holding private health care insurance in Australia can select the physician of their choice for hospital care. Evidence suggests that these private patients get quicker access to treatments for which publicly insured patients face a queue. Queue-jumping by wealthy, privately insured patients is also prevalent in Sweden and in the United Kingdom.
- In Australia, there has been no change in public-sector waiting times following the subsidy policy to encourage private health care insurance. Similarly, evidence from New Zealand and the United Kingdom suggests that, although long public waiting times tend to fuel demand for private health care insurance, having it does not reduce the length of public waiting times.

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[382] See the following documents:
Brian Lee Crowley, *Private Financing, Private Delivery. Two Tier Health Care?*, Presentation to the National Health Care Leadership Conference Panel, Halifax, 27 May 2002.
Stefan Greβ et al., *Private Health Insurance in Social Health Insurance Countries – Market Outcomes and Policy Implications*, Discussion Paper, February 2002.
Jeremiah Hurley et al., *Parallel Private Health Insurance in Australia: A Cautionary Tale and Lessons for Canada*, Centre for Health Economics and Policy Research Analysis, McMaster University, Working Paper 01-12, December 2001.
Colleen M. Flood, Mark Stabile and Carolyn Hughes Tuohy, *Lessons From Away: What Canada Can Learn From Other Health Care Systems*, Document prepared for the Committee, 30 April 2001.
Colleen M. Flood and Tom Archibald (March 2001), *op. cit.*
Raisa Deber *et al.*, "Why not Private Health Insurance? 1. Insurance Made Easy", *Canadian Medical Association Journal*, Vol. 161, No. 5, 7 September 1999, pp. 539-542.
Carolyn H. Tuohy, Colleen M. Flood and Mark Stabile, *How Does Private Finance Affect Public Health Care Systems? Marshalling the Evidence From OECD Countries*, Paper submitted to the Journal of Health Politics, Policy and Law, University of Toronto.

- Evidence from Australia and the United Kingdom suggests that private parallel delivery systems tend to offer a limited range of services for niche markets; they focus on relatively simple, less complex, elective procedures, shifting the burden of the most expensive cases and patients requiring more comprehensive care to the public system.

- In the Netherlands, the government regulates the maximum fees physicians may charge for the treatment of privately insured patients. This has reduced the incentives for preferential treatment of privately insured patients compared to those publicly insured.

- In the Netherlands, two factors help prevent the health care system from becoming a "two-tier" system. First, those who purchase private health care insurance cannot fall back on the public system for some of their health care needs. Private insurers cannot just skim off the easier kinds of care like elective surgery (as happens in the United Kingdom); they must cover all needs. Second, having private insurance does not enable Dutch citizens to jump queues in the public system. It is seen as contrary to a physician's ethical code to select patients with private insurance over other patients; patients of both kinds are treated side-by-side in the same hospitals.

- In Germany, privately insured people tend to receive more comprehensive and faster treatment than do people with public health care insurance.

- In both Germany and the Netherlands, governments quite extensively regulate private health care insurance in order to ensure affordable premiums and limit risk selection by private insurers.

- In Australia, Sweden and the United Kingdom, people who purchase private health care insurance do so out of after-tax income and must continue to pay the same rate of income tax. That is, they pay doubly for health care insurance through general taxation and private premiums. This contrasts with the situation in both Germany and the Netherlands, where residents holding private health care insurance do not contribute to any Sickness Funds.

- Data from 22 OECD countries indicate that increases in private spending on health care are associated over time with decreases in public health care funding. There appears, then, to be some justification for the concern that increasing the proportion of private financing will substitute for and dilute rather than supplement public funding.

On the basis of the evidence available from other countries, the Committee has concluded that no country in which a parallel private health care insurance and delivery system coexists with a public health care insurance scheme can serve as a model that should be adopted, without change, by Canada.

On the basis of the evidence from other countries presented above, the Committee has concluded that no country in which a parallel private health care insurance and delivery system coexists with a public health care insurance scheme can serve as a model that should be adopted, without change, by Canada.

Countries in which parallel private systems compete with publicly funded health care coverage exhibit a number of problems, including: risk selection and cream skimming; no reduction in waiting lists in the public sector; queue jumping; and preferential treatment. These concerns must be appropriately addressed if governments fail, for whatever reason, to provide funding sufficient to assure timely access to care in our publicly funded Canadian health care system.

16.3 Committee Commentary

It is the view of the Committee that, in the absence of governments providing adequate funding, and providers delivering effective and timely health services, to paraphrase section 1 of the Charter, it would no longer be just and reasonable in a free and democratic society to deny Canadians the right to purchase private health care insurance. They should not be denied the right to purchase private supplementary insurance to pay for services they are unable to access in a timely fashion in the publicly funded health care system.

While the Committee would regard such a development as very regrettable, and while many Canadians would strongly oppose it, it is important to recognize two facts:

- first, as indicated in Section 16.2, Canada is the *only* major industrialized country which does not have some element of a parallel private hospital and doctor system;
- second, the *current* Canadian system is not nearly as "one tier" as popular mythology would have Canadians believe.

As a matter of fact, people who can afford it can, and do, go out of Canada (usually to the United States) to access the health services they want if their only alternative is a long queue for those services in Canada.

There is also strong anecdotal evidence to suggest that the situation in Canada is similar to that in Australia, where, in the words of one of the Australian witnesses who testified before the Committee; "access to public (health) services is usually more easily obtained by wealthier and more powerful individuals who understand how the system works and have appropriate contacts in hospital service delivery and administration."

In addition, provincial Workers' Compensation Boards in most provinces receive preferred access to treatment for their clients based on the argument it is necessary to ensure the client gets back to work quickly (which, of course, saves the Workers' Compensation Board money). Moreover, in some provinces, Workers' Compensation Boards have contracts with hospitals for a specified number of beds and diagnostic procedures, thus ensuring quick access to services for WCB patients. They also make direct payments to physicians for services performed, and such payments do not count toward any provincial cap on a physician's income.

All these facts are important for Canadians to reflect on as they consider whether they want the federal government to support or reject the Committee's recommendation for an additional $5-billion investment in health care.

The Committee realizes that some people will be offended by the Committee's raising the potential development of a parallel private system of health care. They are likely to claim that it is possible for Canadians to maintain the current publicly funded system without their having to put more money into the system (e.g., the $5 billion proposed by the Committee). Such critics will probably say that:

- The current system is inefficient and that restructuring will save sufficient money to cover the increasing costs of the system. The Committee has repeatedly acknowledged the critical importance of improving the effectiveness and efficiency of the management and delivery of health care (see Chapter 2 of Volume Five and Chapters 2, 3 and 4 of this report). But the Committee has also repeatedly stated that there is *not* enough evidence to support the hypothesis that efficiency gains alone will be sufficient to avoid having to put large amounts of new funds into the system, particularly if the growing gaps in the system are to be closed. Furthermore, there is widespread to near-universal agreement that substantial amounts of additional money are required to achieve the massive and fundamental changes necessary to create a genuine health care system, capable of achieving acceptable standards of efficiency and effectiveness together with the quality of outcomes we in Canada can, and should, demand.
- In addition, those who hold the view that efficiency measures only are required to refinance the health care system gloss over the key fact that restructuring in any industry costs money - money that has to be spent before the resulting efficiency savings are realized.
- The argument will also be made that the additional $5 billion can come from the federal surplus anticipated over time. This argument, however, completely ignores the fact that there are several other compelling demands on any federal surplus, such as agriculture, the Canadian Armed Forces, infrastructure for Canada's major cities, and so on. The Committee believes that the majority of any federal surplus should *not* be devoted only to health care or even primarily to health care. More important, since surpluses rise and fall (as now) with the state of the economy, it would be irresponsible for government to base the future of the Canadian health care system on the vagaries of the economic cycle.

Therefore, the Committee categorically rejects the position that the problems of Canada's health care system can be solved in a way that is cost-free to individual Canadians. We believe that Canadians, through their federal government, must confront head-on the choice between putting considerably more money into the health care system or having the courts rule in favour of the emergence of a parallel private system.

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Part VIII: The *Canada Health Act*

CHAPTER SEVENTEEN

THE *CANADA HEALTH ACT*

In Volume One, the Committee traced the evolution of the nation-wide principles of the Canadian health care system. We stressed the fact that although the delivery of health care is primarily within provincial/territorial jurisdiction, it does not mean that national interests are absent. For its part, the federal government established national principles and contributed to meeting the cost of health care, first through cost-sharing (from 1966 to 1977) and subsequently by block-funding.[383]

These national principles are currently set out in the *Canada Health Act* (the Act), which was ***unanimously*** enacted by Parliament in April 1984. The five national principles of the Act are:

- The principle of **universality**, which means that public health care insurance must be provided to all Canadians;
- The principle of **comprehensiveness**, which means that medically necessary hospital and doctor services are covered by public health care insurance;
- The principle of **accessibility**, which means that financial or other barriers to the provision of publicly funded health services are discouraged, so that health services are available to all Canadians when they need them;
- The principle of **portability**, which means that all Canadians are covered under public health care insurance, even when they travel within Canada and internationally or move from one province to another;
- The principle of **public administration,** which requires provincial and territorial health care insurance plans to be managed by a public agency on a not-for-profit basis. (This principle says nothing about the ownership structure of a health service *delivery* institution.)

As explained in Volume One, the Committee considers the first four principles of the *Canada Health Act* to be patient-oriented. The fifth principle – that of **public administration** – is of a completely different character. It is not patient-focussed but "is rather the means of achieving the end to which the other four principles are directed."[384] The public administration condition of the *Canada Health Act* is the basis for the single insurer/funder model that the Committee endorsed in Volume Five under Principle One.[385]

Altogether, the five principles of the *Canada Health Act* flow from two overarching objectives for federal health care policy – objectives that the Committee strongly supports as the primary federal health care objectives. As indicated in Volume Four, these two objectives are:

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[383] See Volume One, Chapter Two, pp. 31-44.

[384] Volume One, p. 41.

[385] Volume Five, pp. 23-25.

- To ensure that every Canadian has *timely* access to all medically necessary health services *regardless* of his or her ability to pay for those services.
- To ensure that *no* Canadian suffers *undue* financial hardship as a result of having to pay health care bills.[386]

Each recommendation made in this report with respect to 1) restructuring of the hospital and doctor system, 2) establishment of a national health care guarantee, 3) improvement of the health care infrastructure, and 4) enhancement of federal funding for health care, is designed to make progress toward achieving these two overarching public policy objectives in ways that are consistent with the principles of the *Canada Health Act*. Adopted together, these recommendations will ensure the long-term sustainability of Canadian Medicare.

All recommendations put forward by the Committee in this report are designed to make progress toward achieving the two overarching public objectives of federal health care policy in ways that are consistent with the principles of the **Canada Health Act.**

The Committee's recommendations relating to the expansion of public health care coverage are also intended to preserve the primary objectives of federal health care policy, although we recognize that some of the program characteristics proposed for such expansion do not comply with the *Canada Health Act*. This is particularly true with respect to the out-of-pocket payment provisions up to an annual cap/maximum of 3% of family income proposed for catastrophic prescription drug coverage.

This chapter provides a description and interpretation of the principles of the Act in light of the Committee's recommendations. It is against the principles set out in the *Canada Health Act* and the potential for achieving the two federal health care policy objectives that the Committee's recommendations should be judged.

It is against the principles set out in the **Canada Health Act** ***and the potential for achieving the two federal health care policy objectives that the recommendations of the Committee should be judged.***

17.1 Universality

The principle of universality of the *Canada Health Act* requires that *all* residents of a province or territory be entitled, on uniform terms and conditions, to the publicly funded health services covered by provincial/territorial plans. Universality is often considered by Canadians as a fundamental value that ensures national health care insurance for everyone wherever they live in the country.

Universality does not dictate a particular source of funding for the health care insurance plan. As a matter of fact, the provinces/territories can and do fund their universal plans as they wish, through premiums, dedicated or general taxation. By contrast, universal health care coverage in both Germany and the Netherlands is provided through a system of dedicated payroll taxes.

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[386] Volume Four, p. 16.

Moreover, universality is not necessarily achieved only through public funding. For example, universal coverage for health services is guaranteed by both Sickness Funds (public plans) and private insurers in Germany and the Netherlands. Similarly, the Quebec Pharmacare program provides universal coverage through a combination of public and private insurance.

Perhaps more important, the principle of universal coverage does *not* necessarily mean first-dollar coverage. In fact, countries that provide universal health care coverage, like Australia, Germany, the Netherlands and Sweden, permit user charges and extra-billing for publicly insured services. In Canada, first-dollar coverage for publicly funded hospital and doctor services is required under the provisions of the *Canada Health Act* that explicitly prohibit user charges and extra-billing (see Section 17.3, below).

The Committee feels it is important to stress that the principle of universal coverage does not necessarily mean first dollar coverage.

The principle of universality is one the Committee holds dear. It ensures that access to publicly funded health services is available to everyone, everywhere, and that no one is discriminated against on the basis of such factors as income, age, and health status. We believe that universal insurance coverage and the access it provides to the publicly funded hospital and doctor system has served Canadians extremely well. Accordingly, it should be preserved.

Similarly, the Committee believes strongly that the broadening of public coverage recommended in this report should rest on the principle of universality. In our view, coverage for catastrophic prescription drug costs, post-hospital home care and out-of-hospital palliative care must be provided to *all* Canadians, when they need them.

The Committee is of the view that coverage for catastrophic prescription drug costs, post-hospital home care and out-of-hospital palliative care must be provided to all Canadians, when they need them.

17.2 Comprehensiveness

Health services that must be covered under the *Canada Health Act* are determined on the basis of the "medical necessity" concept under the principle of comprehensiveness. All medically necessary health services provided by hospitals and doctors must be covered under provincial/territorial health care insurance plans.

The determination of what services ought to be considered "medically necessary" is a difficult task. Most Canadians would agree that life-saving cardiac procedures are medically necessary. Most Canadians would also agree that most cosmetic surgery procedures do not meet that criterion. The difficulty comes with those services that lie between these two extremes.

Deciding what health services are to be insured and excluded has always been part of the way Canadian Medicare has functioned. These decisions are made in each province/territory by the government after negotiation with the medical profession. That is why there are differences in what is covered publicly in different provinces/territories. For example, as reviewed in Volume One, the removal of warts is no longer covered in Nova Scotia, New Brunswick, Ontario, Manitoba, Alberta, Saskatchewan and British Columbia, but remains publicly insured in Newfoundland, Quebec and Prince Edward Island. Similarly, stomach stapling is covered in most provinces, but it is not insured in New Brunswick, Nova Scotia or the Yukon, where patients (or their private supplementary health care insurance) must pay for this procedure.[387]

The Committee was told repeatedly that the current process for determining what is and what is not covered under provincial/territorial health care insurance plans is conducted in secret by governments, acting with the provincial/territorial medical associations, with no public input. It is not an open and transparent process. For example, the Canadian Healthcare Association pointed that:

> *Unilateral pronouncements from governments of the delisting of services are certainly not in the best interest of Canadians.*
>
> *(…) Any discussions or decisions regarding the "basket of services" must be evidence based and involve an open and transparent process that meaningfully involves all stakeholders.*[388]

The Committee shares the view of the Canadian Healthcare Association and many other witnesses that transparency requires that the process of deciding what is, and what is not, to be publicly insured should be much more open than it has been historically and is now.

The Committee shares the view of many witnesses that transparency requires that the process of deciding what is, and what is not, to be publicly insured should be much more open than it has been historically and is now.

For this reason, the Committee enunciated Principle Four in Volume Five, which states that the determination of what should be covered under public health care insurance should be done through an open and transparent process.[389] This principle also reflects the views expressed in the report of the Clair Commission in Quebec and the Mazankoski report in Alberta, both of which recommended that consideration should be given to reviewing the principle of comprehensiveness of the *Canada Health Act*. Both recommended the establishment of a permanent committee, made up of citizens, ethicists, health care providers and scientists, to review and make decisions on the range of services that should be covered publicly. Such a review would set the boundaries between publicly insured and privately funded health services; it would also lead to evidence-based (as opposed to the current negotiated process) decision making with respect to what services should be covered under public health care insurance.

The Committee believes strongly that the permanent committee charged with revising the set of publicly funded health services should be broad-based in membership and not be composed entirely of experts. We believe that input from those who would be directly affected by the committee's decisions – namely, citizens – is essential if the process is to be truly open and is to have public credibility and acceptability.

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[387] Volume One, pp. 98-99.

[388] Canadian Healthcare Association, Brief to the Committee, May 2002, pp. 3-4.

[389] Volume Five, pp. 30-32.

The Committee also believes that there should be national standards to define those services covered publicly in each province/territory. This would bring more uniformity to public health care coverage across the country. Therefore, the Committee recommends that:

The federal government, in collaboration with the provinces and territories, establish a permanent committee – the Committee on Public Health Care Insurance Coverage – made up of citizens, ethicists, health care providers and scientists.

The Committee on Public Health Care Insurance Coverage be given the mandate to review and make recommendations on the set of services that should be covered under public health care insurance.

The Committee on Public Health Care Insurance Coverage report its findings and recommendations to the National Health Care Council.

As its first task, the Committee on Public Health Care Insurance Coverage be charged with developing national standards upon which decisions for public health care coverage will be made.

It must be recognized that revising the comprehensive basket of publicly insured health services is not intended to reduce costs. It is intended to improve both transparency and evidence-based decisions with respect to comprehensiveness of publicly funded health services. The purpose of such a review is to use clinical, evidence-based, research to ensure that publicly insured health services are those that are most clinically effective in preventing disease, restoring and maintaining health, and alleviating pain and suffering.

Another important critique raised with respect to the principle of comprehensiveness of the *Canada Health Act* relates to its limited scope of coverage. In Volume One, the Committee stated that the *Canada Health Act* is very limited: it is centred on medically necessary health services provided by hospitals and doctors. Moreover, the Act applies to a shrinking range because fewer services are provided now in hospitals. Thanks to new knowledge and technologies, many more health services can be provided safely and effectively on an ambulatory basis or at home. Hospitals stays are shorter; drug therapy often enables people to avoid hospital-based care altogether.

As shown in Volume Three, there is a sharp contrast between Canada and other OECD countries in terms of the scope of its public health care coverage. Many countries with a similar share of public spending in total health care expenditures provide coverage that is much broader than Canada's, encompassing such items as prescription drugs (Australia, Germany, Sweden, the United Kingdom), home care (Germany, Sweden), and long-term care (Germany, the Netherlands).

As described elsewhere in this report, when services and prescription drugs are provided outside hospitals, they fall outside the ambit of the *Canada Health Act*. As a result, these services are not usually provided cost-free to the patients, nor are they necessarily provided in accordance with the principles of accessibility, comprehensiveness and universality.[390] Moreover, testimony received by the Committee suggests that, more and more often, individual Canadians bear heavy financial burdens as a result of incurring very high out-of-pocket expenditures to obtain these services.

Based on the evidence it gathered throughout its hearings, and as set out in Chapters Seven, Eight and Nine of this report, the Committee has come to the conclusion that there is a need to expand public health care insurance coverage to encompass three new applications: catastrophic prescription drug costs, post-hospital home care costs, and palliative home care costs.

It is the view of the Committee that broadening public health care coverage to encompass catastrophic prescription drug costs, post-hospital home care costs and palliative home care costs is consistent with the primary objectives of federal health care policy. This is particularly true with respect to catastrophic prescription drug costs if we are to meet the second objective of federal health care policy – that no Canadian suffers undue financial hardships as a result of having to pay health care bills.

It is the view of the Committee that broadening public health care coverage to encompass catastrophic drug costs, post-hospital home care costs and palliative home care costs is consistent with the primary objectives of federal health care policy.

The Committee acknowledges that national parameters will have to be developed for both post-hospital home care and palliative care delivered out-of-hospital. This would be consistent with the original intent of the national health care insurance program. The Committee on Public Health Care Insurance Coverage could play a major role in this area. Therefore, the Committee recommends that:

> **The Committee on Public Health Care Insurance Coverage be charged with determining the national parameters applicable to post-hospital home care and palliative care delivered in the home.**

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[390] Volume One, pp. 35-36.

17.3 Accessibility

The principle of accessibility in the *Canada Health Act* stipulates that Canadians should have "reasonable access" to insured hospital and doctor services. However, the Act does not provide a clear definition as to what constitutes reasonable access. Although originally the primary concern was to eliminate financial barriers, lately the concern over access to health care has been associated primarily with the problem of waiting times. There is no doubt that a major problem of the current health care system is one of *timely* access. As stated earlier, it is the view of the Committee that "timely access" describes more accurately what Canadians expect from the publicly funded health care system than "reasonable access."

In the view of the Committee, the National Health Care Guarantee is the essence of a patient-oriented system and of the health care "contract" between Canadians and their governments.

The Committee believes that, since governments have the responsibility of providing funding sufficient to ensure an adequate supply of the essential services of hospitals and doctors, this responsibility carries with it the obligation to ensure reasonable standards of access. This is the essence of a patient-oriented system and of the health care "contract" between Canadians and their governments. It is the view of the Committee that a maximum waiting time guarantee for publicly insured health services would meet this obligation. For this reason, we have, in Chapter Six, recommended establishment of a National Health Care Guarantee.

How (and where) does a National Health Care Guarantee fit in the context of the *Canada Health Act*? There are a number of possibilities:

1. The health care guarantee could be added as a sixth principle to the Act. As such, provincial and territorial governments that failed to comply with the National Health Care Guarantee would be subject to the financial penalties currently present in the *Canada Health Act*.

2. The health care guarantee could be appended to the *Canada Health Act* or expressed in the preamble of the Act. This excludes the possibility of enforcement or penalty by the federal government.

3. The National Health Care Guarantee could be introduced in new legislation, similar to the *Canada Health Act*, but subject to different principles, different enforcement mechanisms and different penalties.

The Committee has concluded that the National Health Care Guarantee would be most effective if implemented through legislation **distinct** ***from the*** **Canada Health Act.**

The Committee has concluded that the National Health Care Guarantee would be most effective if implemented through legislation *distinct* from the *Canada Health Act*. A new Act giving effect to the National Health Care Guarantee would ensure that the definition of *timely* access to needed hospital and doctor services is set uniformly across the country and that the federal government plays a major role in this guarantee. Therefore, the Committee recommends that:

The federal government enact new legislation establishing the National Health Care Guarantee. The new legislation should include a definition of the concept of "timely access" that will relate to such a guarantee.

Another important provision of the *Canada Health Act* relating to the accessibility criterion is that insured people have uniform access to hospital and doctor services without any financial barrier. It is for this reason that user charges and extra-billing are not permitted for services covered under the *Canada Health Act*.

However, the question of whether patients should make a financial contribution with respect to the new publicly insured health services we recommend is one that should be addressed. The Committee believes that Canada's public purse cannot afford first dollar coverage for the broader range of health services the Committee is recommending. We have suggested, therefore, in our proposal for catastrophic prescription drug cost coverage that individuals make a financial contribution to the cost of the prescription drugs they take.

The question of whether patients should make a financial contribution with respect to new publicly insured health services is one that should be addressed. The Committee believes that Canada's public purse cannot afford first-dollar coverage for the broader range of health services the Committee is recommending.

Requiring some financial contribution from patients for the expanded set of publicly insured services is not consistent with the *Canada Health Act*. Therefore, it is not possible simply to add "catastrophic prescription drugs" to the current list of medically required services set out in the *Canada Health Act*.

The Committee's proposal to expand public health care coverage to post-hospital home care for a three-month period and to insure at home palliative care costs appears to be consistent with both the spirit and the letter of the *Canada Health Act*. However, the Committee is recommending that this expansion in coverage be funded through a new cost-sharing mechanism totally different from the CHST. This additional federal funding will be subject to a number of conditions (including accountability and transparency) that are not currently found under the CHST or the *Canada Health Act*. Federal funding for coverage of catastrophic prescription drugs will also be provided through the new funding mechanism, not the CHST.

The Committee believes that the expansion of public coverage to include catastrophic prescription drugs, post-hospital home care and palliative care in the home must be authorized through new federal legislation, and not under the **Canada Health Act.**

For all these reasons, the Committee believes that the expansion of public coverage to include catastrophic prescription drugs, post-hospital home care and palliative care in the home must be authorized through new federal legislation, and not under the *Canada Health Act* (see Section 17.6 below).

17.4 Portability

The portability criterion of the *Canada Health Act* requires that the provinces and territories extend medically necessary hospital and physician coverage to their residents during temporary absences (business or vacation) from the province or territory. This allows individuals to travel away from their home province or territory and yet retain their public health care insurance coverage. This portability requirement applies to emergency health services: residents must seek prior approval from their home province health care insurance plan for non-emergency (elective) health services provided out-of-province.

The principle of portability also applies when residents move from one province or territory to another: they must retain their coverage for insured health services by the "home" province during a minimum waiting period in the "host" province that does not exceed three months. After the waiting period, the new province or territory of residence assumes the responsibility for public health care coverage.

Canadians are also entitled to portable public health care insurance coverage when they are temporarily out of the country. Most provinces, however, limit the reimbursement of the cost of emergency health services obtained outside Canada under their public health care insurance. For this reason, Canadians are strongly encouraged to purchase supplementary private health care insurance when they travel in another country.

Within Canada, the portability provision of the *Canada Health Act* is generally implemented through bilateral reciprocal billing agreements among the provinces and territories for hospital and physician services. These agreements are interprovincial, not federal, and signing them is not a requirement of the *Canada Health Act*.[391] The rates prescribed within these agreements are those of the host province (apart from Quebec, which pays home-province rates), and the agreements are meant to ensure that Canadian residents travelling in another province/territory, for the most part, will not face any user charges at the point of service for medically required hospital and physician services.

Reciprocal billing is a convenient administrative arrangement. However, it is but one method of satisfying the portability criterion of the Act. A requirement for patients to pay "up front" and seek reimbursement from their home province or territory also satisfies the portability criterion of the Act as long as access to a medically necessary insured service is not denied based on the patient's inability to pay.[392]

Overall, the principle of portability under the *Canada Health Act* provides Canadians with peace of mind when they travel within Canada or when they move from one province/territory to another. Perhaps more important, the principle of portability is closely linked to that of universality and it certainly encourages uniformity in public health care coverage.

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[391] The Government of Quebec has not always been signatory to these agreements.

[392] At present, portability does not always apply to Quebec residents as many providers in other provinces will not treat Quebec residents if they do not pay the medical fees upfront. In many cases, this is not possible and Quebec residents have been transferred in ambulance for long distances in difficult circumstances back to Quebec.

The Committee believes that portability is an important national principle that should be maintained when expanding public coverage to catastrophic prescription drug costs, post-hospital home care and palliative care costs.

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17.5 Public Administration

The public administration criterion of the *Canada Health Act* relates to the ***administration*** of provincial/territorial health care insurance plans for medically necessary health services. It stipulates that provincial/territorial health care insurance plans must be administered by a public agency on a not-for-profit basis. The principle of public administration was underlined in Volume Five under Principle One, which states that there should be a single funder/insurer – the government – for hospital and doctor services covered under the *Canada Health Act.*[393]

In the view of the Committee, a single funder system yields considerable efficiencies over any form of multi-funder arrangement, including administrative, economic and informational economies of scale. Furthermore, since a publicly funded hospital and doctor system has become a fundamental element of Canadian society, the Committee believes that the single funder should be government.

In the view of the Committee, a single funder system yields considerable efficiencies over any form of multi-funder arrangement, including administrative, economic and informational economies of scale. Furthermore, since a publicly funded hospital and doctor system has become a fundamental element of Canadian society, the Committee believes that the single funder should be government.

In Volume Five, we explained that a compelling argument for the retention of a single public funder or insurer for the hospital and doctor system is that Canadians support it strongly. The Committee agrees that this central element of our system must be maintained, ***provided*** that the system meets appropriate standards for high-quality services delivered in a timely manner.

Many witnesses told the Committee that giving primary financial responsibility to a single funder provides the Canadian health care system with a more efficient administration of health care insurance than is possible under a multi-funder system. They also testified that Canada's publicly financed single insurer system for medically necessary health services eliminates costs associated with the marketing of competitive health care insurance policies, billing for and collecting premiums, and evaluating insurance risks.

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[393] Volume Five, pp. 23-25.

Another strong argument in favour of public health care insurance is the fact that very few Canadians can afford not to be covered. It therefore makes sense to have everyone covered by a single plan. A single insurer system providing universal coverage also means that no one will deny themselves needed health care because they have what they feel to be a more pressing use for their money (perhaps for food, shelter, clothing, etc.). Nor will anyone be denied necessary care due to their inability to pay.

Yet another important advantage relates to the principle of risk sharing. The more who share the risk (all Canadians), the lower the cost of insuring against all risks.

The Committee also heard that a single insurer makes a lot of economic sense for Canadian industry and is an important element of Canadian competitiveness. This point was put eloquently by Paul Darby, Director of Economic Forecasting and Analysis, Conference Board of Canada, when he stated:

> *(…) our largely single payer system has significant efficiency advantages, in general, and that these in turn help improve our industrial competitiveness. We should not lose these advantages.*[394]

A single funder model implies that there will not be, within Canada, a parallel, private insurance sector that competes with public insurance for the funding of hospital and doctor services under the *Canada Health Act*, at least in those hospitals and with those doctors that care for publicly insured patients.

Up to now, the single insurer model has discouraged the growth of a second tier of health care that many claim would pose a significant threat to Canada's publicly funded health care system. We point out, however, that parallel public and private health care systems exist in most other industrialized countries.

In Chapters Five, Six and Sixteen, the Committee has raised the concern that laws that, in effect, prevent the development of a parallel private system, and hence help preserve the principle of public administration of the *Canada Health Act*, may be struck down by the courts if the publicly funded and insured health care system fails to provide *timely* and quality care. Should this happen, the principle of public administration would have to be revisited. The Committee believes that, Through implementation of its recommendations, our publicly funded health care system can provide timely access to services of very high quality and that Canada's single insurer model for hospitals and doctors will be preserved.

It is the hope of the Committee that Canada's single insurer model for hospitals and doctors will be preserved.

As noted in Volume One, it is equally important to understand clearly what the public administration principle of the *Canada Health Act* does not mean. This principle refers to the *administration* of health care insurance coverage; it does not deal with the *delivery* of publicly insured health services. The Act does not prevent provinces and territories from allowing private (for-profit and not-for-profit) health care providers, whether individual or institutional, to deliver, and be reimbursed for, provincially insured health services, so long as extra-billing or user charges are not involved. This is, in fact, what Canadian Medicare has been from the start – a national health care insurance program based primarily on the *private* (both for-profit and not-for-profit) *delivery* of *publicly insured* hospital and doctor services.

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[394] Paul Darby, Brief to the Committee, 3 June 2002, p. 2.

The Committee is concerned that the principle of public administration is poorly understood, particularly because of the confusion between administering public health care insurance and delivering publicly insured health services. We believe that the federal government, namely through Health Canada, should clearly articulate the meaning of "public administration" and make it clear that the *Canada Health Act* does not prohibit in any way the private delivery, either for-profit or not-for-profit, of publicly funded health services. This would greatly improve the current debate about health care in this country. Therefore, the Committee recommends that:

In Volume One, the Committee noted that it is important to understand clearly what the public administration principle of the Canada Health Act does not mean. This principle refers to the administration of health care insurance coverage; it does not deal with the delivery of publicly insured health services.

The principle of public administration of the *Canada Health Act* be maintained for publicly insured hospital and doctor services. That is, there should be a single insurer – the government – for publicly insured hospital and doctor services delivered by either public or private health care providers and institutions.

The federal government, through Health Canada, clarify the meaning of the concept of public administration under the *Canada Health Act* so as to recognize explicitly that this principle applies to the administration of public health care insurance, not to the delivery of publicly insured health services.

While the Committee is convinced that the principle of public administration must be maintained for the hospital and doctor system, it would be very difficult in our view to extend it to the broader range of health services recommended in this report. This is particularly true with respect to the expansion of public coverage against catastrophic prescription drug costs.

The Committee believes that the expansion of coverage to include catastrophic prescription drug costs should be based on a partnership between the public and the private sectors. This is why the recommendations made in Chapter Seven are based on the collaboration of public and private insurers to ensure universal coverage for catastrophic prescription drug costs.

Prescription drug coverage is currently provided by many insurers, ranging from governments to private insurance companies. In fact, the private drug insurance industry is already well established in Canada and it appears to be functioning well. The Committee believes, and has recommended in Chapter Seven, that the expansion of coverage to include catastrophic prescription drug costs should be based on a partnership between the public and the private sectors to ensure universal coverage for catastrophic drug costs.

17.6 Committee Commentary

The Committee has no hesitation in saying that in-depth reform of the publicly funded hospital and doctor system can take place within the five national principles of the *Canada Health Act*. We believe that the Act has served Canadians relatively well in terms of providing universal and uniform coverage for hospital and doctor services. We feel that the four patient-oriented principles of the Act should be maintained for hospital and doctor services, while the principle of public administration should be clarified.

However, the Committee believes that Canadian Medicare and the *Canada Health Act* must be supplemented by two new pieces of legislation. First, as explained in Section 17.3, new federal legislation must be enacted to implement the National Health Care Guarantee. This legislated health care guarantee will improve access to the set of hospital and doctor services that are currently insured under the *Canada Health Act*. Second, the Committee's proposal to expand public coverage also requires the enactment of new legislation:

- Coverage for catastrophic prescription drug costs requires the financial participation of both public plans and private insurers (collaboration that is not consistent with the principle of public administration of the *Canada Health Act*).
- Coverage for catastrophic prescription drug costs requires that individuals make a financial contribution to cover part of the cost of the insured service (this is not consistent with the first-dollar coverage contained under the principle of accessibility of the Act).
- Coverage for catastrophic prescription drugs, post-hospital home care for a period of three months and palliative home care costs will be funded through a federal funding mechanism that is distinct from the current CHST (the principles of the *Canada Health Act* relate to the CHST only).
- The Committee believes strongly that additional federal funding provided for the expansion of public coverage must be based on specific conditions related to transparency and accountability (these principles are totally absent from the *Canada Health Act*).

While principles other than those of the *Canada Health Act* are needed for the new programs proposed in the report, the underlying value related to those services, namely, providing high-quality services on the basis of need, should remain. Similarly, access to reasonably comparable

The Committee believes that, while principles other than those of the* Canada Health Act *are needed, the underlying value of receiving services on the basis of need should remain.

services for all Canadians everywhere in the country must be assured under the legislation covering the new programs. This comparability requires the development of national standards. These should apply to all publicly funded services, whether delivered by private for-profit, private not-for-profit or public health care providers and institutions. Therefore, the Committee recommends that:

> **The federal government enact new legislation instituting health care coverage for catastrophic prescription drugs, post-hospital home care and some palliative care in the home. This new legislation should explicitly spell out conditions relating to transparency of decision making and accountability.**

CONCLUSION

Two years ago, at the outset of the Committee's work, the Committee endorsed two major public policy objectives for Canada's heath care system:

- To ensure that every Canadian has timely access to medically necessary health services regardless of his or her ability to pay for those services, and
- To ensure that no Canadian suffers undue financial hardship as a result of having to pay health care bills.

Implicit in these two objectives, particularly the first, is the requirement that the medically necessary services provided under Medicare be of high quality. Clearly, providing access to services of inferior quality would defeat the purpose of Canada's health care system.

In addition, the Committee recognized that the value of fairness is also an important component of Canadians' views of the health care system. This value of fairness underlies the patient-oriented principles of a universal, comprehensive, portable and accessible system that the Committee – and Canadians – strongly support.

But, to Canadians, fairness also means equity of access to the system – wealthy Canadians should not be able to buy their way to the front of waiting lists in Canada. Repeated public opinion polling data have shown that having to wait months for diagnostic or hospital treatment is the greatest concern and complaint that Canadians have about the health care system. The solution to this problem is not, as some have suggested, to allow wealthy Canadians to pay for services in a private health care institution. Such a solution would violate the principle of equity of access. The solution is the care guarantee as recommended in this report.

Based on evidence presented at Committee hearings over the past two years as well as on public opinion polling data, the Committee is also aware that Canadians believe that the current system is inefficient. Moreover, Canadians are not prepared to invest additional money into the system until these inefficiencies are eliminated. The Committee realizes that changing this public perception of an inefficient system will not be easy. It will require the introduction of *incentives* to encourage all the components of the system to function more efficiently. It will also require that the system function in a much more transparent and accountable fashion, including in the ways in which public money is spent.

In formulating its recommendations, the Committee also took account of two additional factors. First, the Committee believes that if the second public policy objective given above – the no undue financial hardship objective – is to be met, steps must be taken *now* to begin to close the major gaps in the health care safety net. While the Committee believes that Canadians who are genuinely in need of help, and cannot afford to pay for it, should receive the assistance they need from public funds, this does not mean that what is needed are new first-dollar coverage programs in areas such as pharmacare or home care. In the Committee's view prudence requires that any expansion of the current system to begin to close the gaps in it must be done in small, manageable steps.

Anyone proposing a plan to reform and renew the health care system has an obligation to say how their plan of reform will be paid for. The only way Canadians can develop an informed opinion on the merits of a proposed plan of reform is if they can clearly understand the benefits that will result from the plan, and what it will cost them to have the plan implemented.

The second factor that is reflected in the Committee's recommendations is the belief that anyone proposing a plan to reform and renew the health care system has an obligation to say how their plan of reform will be paid for. Moreover, the payment method must be described in terms that are meaningful to individual Canadians. The only way Canadians can develop an informed opinion on the merits of a proposed plan of reform is if they can clearly understand the benefits that will result from the plan, and what it will cost them to have the plan implemented.

Not to give a revenue-raising plan would also mean that the Committee had failed to meet the test of transparency and accountability, which it has insisted throughout its recommendations must apply to the health care system as a whole.

It is for this reason that the Committee has taken the extremely unusual (some have even described it as unique) step of both costing our recommendations ***and*** putting forward a recommended option for raising the new federal revenue required to implement fully our recommendations. To fail to do this would, in our view, perpetuate the myth that health care is a "free" good. This would play directly into the hands of those who oppose reform. Not to give a revenue-raising plan would also mean that the Committee had failed to meet the test of transparency and accountability, which it has insisted throughout its recommendations must apply to the health care system as a whole.

The Committee understands that the implementation of its set of recommendations will require considerable *behavioral change on the part of all participants* in the health care system. For example:

- The change to service-based funding will alter the way in which hospitals are managed. It will make hospital management, and the health care professionals working in a hospital, much more conscious of which procedures they do efficiently and which they do inefficiently. It will also mean that hospitals in large urban areas will face competition from other hospitals and specialist clinics.
- The changes involved in primary health care reform will require family physicians to accept changes to the way they are remunerated (by replacing straight fee-for-service by a remuneration model that is primarily capitation with an added component of fee-for-service). It will also require that modifications be made to the scope of practice rules for all health care professionals in order to ensure that such rules are not barriers to health care professionals being able to use their skills to the fullest extent for which they have been trained.

- The changes involved in primary health care reform will also require that patients agree to stay with their choice of family physician for a year, unless they move to a different community. The recommendation to set up a system of electronic health records will require that patients agree to give the necessary approval to enable an efficient use of patient electronic health records. (As explained in Chapter 10, the Committee believes that a system of electronic health records can be built, and the resulting information system operated, in a manner that is entirely consistent with the spirit as well as the letter of privacy laws.)

- Provincial/territorial governments will need to change a significant aspect of their approach to the health care system by agreeing to a health care guarantee, thus accepting responsibility for the consequences of their past decisions to cut budgets and ration the supply of health care services.

- Provincial/territorial governments will also have to move away from their current command-and-control approach to health care by giving regional health authorities sufficient autonomy and by allowing the system of incentives, with its associated behavioral change, to generate the desired results.

- The federal government will have to agree to the creation of an arms-length fund, overseen by a Health Care Commissioner and a National Health Care Council who will advise the government on how money in the fund should be spent. This advice should be made public, and there should also be an annual public accounting of how funds earmarked for health care are actually spent. This is an essential step in restoring public confidence in the system.

- The federal government will also have to accept that it has a major leadership role to play in financially sustaining the infrastructure that is essential to a successful national health care system. Included in this infrastructure are the nation's 16 Academic Health Sciences Centres, the national supply of human resources in the health care sector, technology, information systems and research.

- The federal government will also have to accept that it has a major role to play in financing, and marketing, programs of health promotion and chronic disease prevention.

Finally, it is important to stress how critical the objectives of greater accountability and transparency are to the Committee's views on the kinds of reform that are needed in the health care system, and the critical role that improved information, at all levels of the system, must play in implementing these objectives. This increased information is needed for the following reasons:

- first, to make more transparent the processes by which resource allocation decisions are made – principally with regard to money, but also including human resources;
- second, to enhance the accountability of the people, institutions and governments that decide what types of services will be covered by public health care insurance and how much of any particular service will be provided;
- third, and perhaps most important, to change the public debate from a debate about dollars to a debate about services and service levels.

Canadians have a right to debate the question of whether they are willing to pay more for improved levels of service, and they have a right to understand the linkages between funding levels and service levels. Changing the nature of the public debate about health care will mark a significant step towards gaining public support for restructuring and renewing the publicly funded hospital and doctor system.

The Committee fully recognizes that its set of recommendations will be subject to close critical scrutiny. This is entirely understandable in such a value-laden public policy issue as health care. In fact, it is likely that each reader of this report will support his or her own unique subset of recommendations.

We ask readers, however, to keep in mind that no major reform of any large system, particularly one as complex as the health care system, is ever perfect. There is no perfect solution. Everyone involved will have to be prepared to compromise in order to make reform work for the benefit of all Canadians. Insisting on perfection, or attempting to obtain everything one wants, will doom reform to failure.

There is no perfect solution. Everyone involved will have to be prepared to compromise in order to make reform work for the benefit of all Canadians. Insisting on perfection, or attempting to obtain everything one wants, will doom reform to failure.

Similarly, reform will fail if people insist on addressing all health care problems before beginning to make progress on some of them, particularly on the hospital and doctor system. These tendencies, along with a focus on self-interest by those employed in the system, explain why reform has failed in the past.

Recognizing these dangers, we have worked hard to develop a set of recommendations we believe to be pragmatic, middle-of-the-road in ideological terms, workable and that will lead to substantial improvements in the hospital and doctor sectors of the health care system. We believe that a steady pace of reform is the way to make the restructuring and renewal of Canada's health care system possible.

We trust that those involved in all aspects of the country's health care system, and indeed all Canadians, will consider the recommendations with the same pragmatic approach as the Committee, and that everyone will be prepared to make some compromises in order to meet our common goal: having a fiscally sustainable health care system of which Canadians can be truly proud.

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APPENDIX A

LIST OF RECOMMENDATIONS BY CHAPTER

The Committee recommends that:

CHAPTER ONE:

THE NEED FOR AN ANNUAL REPORT ON THE STATE OF THE HEALTH CARE SYSTEM AND THE HEALTH STATUS OF CANADIANS

A National Health Care Commissioner and National Health Care Council

New federal/provincial/territorial committee made up of five provincial/territorial and five federal representatives be struck. Its mandate would be to appoint a National Health Care Commissioner and the other eight members of a National Health Care Council from among the Commissioner's nominees;

The National Health Care Commissioner be charged with the following responsibilities:

- To put nominations for members to a National Health Care Council before the F/P/T committee and to chair the Council once the nominees have been ratified;
- To oversee the production of an annual report on the state of the health care system and the health status of Canadians. The report would include findings and recommendations on improving health care delivery and health outcomes in Canada, as well as on how the federal government should allocate new money raised to reform and renew the health care system;
- To work with the National Health Care Council to advise the federal government on how it should allocate new money raised to reform and renew the health care system in the ways recommended in this report;
- To hire such staff as is necessary to accomplish this objective and to work closely with existing independent bodies to minimize duplication of functions.

The federal government provide $10 million annually for the work of the National Health Care Commissioner and the National Health Care Council that relates to producing an annual report on the state of the health care system and the health status of Canadians, and to advising the federal government on the allocation of new money raised to reform and renew the health care system.

CHAPTER TWO:

HOSPITAL RESTRUCTURING AND FUNDING IN CANADA

Service Based Funding

Hospitals should be funded under a service-based remuneration scheme. This method of funding is particularly well suited for community hospitals located in large urban centres. In order to achieve this, a number of steps must be undertaken:

- A sufficient number of hospitals should be required to submit information on case rates and costing data to the Canadian Institute for Health Information;
- The Canadian Institute for Health Information, in collaboration with the provinces and territories, should establish a detailed set of case rates to reduce incentives to up-code.
- The federal government should devote ongoing funding to the Canadian Institute for Health Information for the purpose of collecting and estimating the data needed to establish service-based funding.
- The shift to service-based funding should occur as quickly as possible. The Committee considers a five-year period to be a reasonable timeframe for the full implementation of the new hospital funding.

Service-based funding should be augmented by an additional funding method that would take into account the unique services provided by Academic Health Sciences Centres, including teaching and research.

In developing a service-based remuneration scheme for financing of community hospitals, consideration be given to the following factors:

- Isolation: hospitals located in rural and remote areas are expected to incur higher costs than those in large urban centres. An adjustment should reflect this fact.
- Size: small hospitals are expected to incur higher costs per weighted case than larger hospitals. An adjustment should recognize this fact.

Capital Support for Hospitals

The federal government provide capital financial support for the expansion of hospitals located in areas of exceptionally high population growth; that is, areas in which the population growth exceeds the average rate of growth in the province by 50% or more. Such federal financial support should account for 50% of the total capital investment needed. In total, the federal government should devote $1.5 billion to this initiative over a 10-year period, or $150 million annually.

The federal government should encourage the provinces and territories to explore public-private partnerships as a means of obtaining additional investment in hospital capacity.

The federal government contribute $4 billion over the next 10 years (or $400 million annually) to Academic Health Sciences Centres for the purpose of capital investment.

Academic Health Sciences Centres be required to report on their use of this federal funding.

CHAPTER THREE

DEVOLVING FURTHER RESPONSIBILITY TO REGIONAL HEALTH AUTHORITIES

Regional health authorities in major urban centres be given control over the cost of physician services in addition to their responsibility for hospital services in their regions. Authority for prescription drug spending should also be devolved to RHAs.

Regional health authorities should be able to choose between providers (individual or institutional) on the basis of quality and costs, and to reward the best providers with increased volume. As such, RHAs should establish clear contracts specifying volume of services and performance targets.

The federal government should encourage the devolution of responsibility from provincial/territorial governments to regional health authorities, and participate in evaluating the impact of internal market reforms undertaken at the regional level.

CHAPTER FOUR

PRIMARY HEALTH CARE REFORM

The federal government continue to work with the provinces and territories to reform primary care delivery, and that it provide ongoing financial support for reform initiatives that lead to the creation of multi-disciplinary primary health care teams that:

- are working to provide a broad range of services, 24 hours a day, 7 days a week;
- strive to ensure that services are delivered by the most appropriately qualified health care professional;
- utilise to the fullest the skills and competencies of a diversity of health care professionals;
- adopt alternative methods of funding to fee-for-service, such as capitation, either exclusively or as part of blended funding formulae;
- seek to integrate health promotion and illness prevention strategies in their day-to-day work;

- progressively assume a greater degree of responsibility for all the health and wellness needs of the population they serve.

The federal government commit $50 million per year of the new revenue the Committee has recommended it raise to assist the provinces in setting up primary care groups.

CHAPTER FIVE

TIMELY ACCESS TO HEALTH CARE

There are no recommendations in this chapter.

CHAPTER SIX

THE HEALTH CARE GUARANTEE

For each type of major procedure or treatment, a maximum needs-based waiting time be established and made public.

When this maximum time is reached, the insurer (government) pay for the patient to seek the procedure or treatment immediately in another jurisdiction, including, if necessary, another country (e.g., the United States). *This is called the Health Care Guarantee.*

The process to establish standard definitions for waiting times be national in scope.

An independent body be created to consider the relevant scientific and clinical evidence.

Standard definitions focus on four key waiting periods – waiting time for primary health care consultation; waiting time for initial specialist consultation; waiting time for diagnostic tests; waiting time for surgery.

CHAPTER SEVEN

EXPANDING COVERAGE TO INCLUDE PROTECTION AGAINST CATASTROPHIC PRESCRIPTION DRUG COSTS

The federal government introduce a program to protect Canadians against catastrophic prescription drug expenses.

For all eligible plans, the federal government would agree to pay:

- 90% of all prescription drug expenses over $5,000 for those individuals for whom the combined total of their out-of-pocket expenses and the contribution that a province/territory incurs on their behalf exceeds $5000 in a single year;

- 90% of prescription drug expenses in excess of $5,000 for individual private supplementary prescription drug insurance plan members for whom the combined total of their out-of-pocket expenses and the contribution that the private insurance plan incurs on their behalf exceeds $5,000 in a single year.
- the remaining 10 % would be paid by either a provincial/territorial plan or a private supplementary plan.

In order to be eligible to participate in this federal program:

- provinces/territories would have to put in place a program that would ensure that no family of the province/territory would be obliged to pay more than 3% of family income for prescription drugs;
- sponsors of existing private supplementary drug insurance plans would have to guarantee that no individual plan member would be obliged to incur out-of-pocket expenses that exceed $1,500 per year; this would cap each individual plan member's out-of-pocket costs at either 3% of family income or $1,500, whichever is less.

The federal government work closely with the provinces and territories to establish a single national drug formulary.

CHAPTER EIGHT

EXPANDING COVERAGE TO INCLUDE POST-ACUTE HOME CARE (PAHC)

When Does PAHC Coverage Begin and End

An episode of PAHC should be defined as all home care services received between the first date of service provision following hospital discharge, if that date occurs within 30 days of discharge, and up to three months following hospital discharge.

PAHC Financing Directed to Hospitals

Financing for post-acute home care should be first directed to hospitals.

In order to encourage innovation and service integration, and to enhance the efficient and effective provision of necessary health care irrespective of the setting in which such care is received, a service-based method of reimbursement for PAHC should be developed in conjunction with service-based arrangements for each episode of hospital care.

Range of Services Covered

The range of services, products and technologies (including prescription drugs) that may be used to facilitate the use of home care following hospital care not be restricted.

PAHC Funded Through Service Based Funding

Hospitals have the option to develop contractual relationships directly with home care service providers or with transfer agencies that may provide case management and service provision arrangements.

Contracts formed with home care service providers should include, in addition to service-based reimbursement arrangements, mechanisms to monitor service quality, performance and outcome.

PAHC Programs Should Be Cost-Shared

The federal government establish a new National Post-Acute Home Care Program, to be jointly financed with the provinces and territories on a 50:50 basis.

The PAHC program be treated as an extension of medically necessary coverage already provided under the *Canada Health Act,* and that therefore the full cost of the program should be borne by government (shared equally by the provincial/territorial and federal levels).

CHAPTER NINE

EXPANDING COVERAGE TO INCLUDE PALLIATIVE HOME CARE

The federal government agree to contribute $250 million per year towards a National Palliative Home Care Program to be designed with the provinces and territories and co-funded by them on a 50:50 basis.

The federal government examine the feasibility of allowing Employment Insurance benefits to be provided for a period of six weeks to employed Canadians who choose to take leave to provide palliative care services to a dying relative at home.

The federal government examine the feasibility of expanding the tax measures already available to people providing care to dying family members or to those who purchase such services on their behalf.

The federal government amend the Canada Labour Code to allow employee leave for family crisis situations, such as care of a dying family member, and that the federal government work with the provinces to encourage similar changes to provincial labour codes.

The federal government take a leadership role as an employer and enact changes to Treasury Board legislation to ensure job protection for its own employees caring for a dying family member.

CHAPTER TEN

THE FEDERAL ROLE IN HEALTH CARE INFRASTRUCTURE

Health Care Technology

The federal government provide funding to hospitals for the express purpose of purchasing and assessing health care technology. The federal government should devote a total of $2.5 billion over a five-year period (or $500 million annually) to this initiative. Of this funding, $400 million should be allocated annually to Academic Health Sciences Centres, while $100 million should be provided annually to community hospitals. The community hospital funding should be cost-shared on a fifty-fifty basis with the provinces, while the Academic Health Sciences Centre funding should be 100% federal.

The institutions benefiting from this program be required to report on their use of such funding.

Electronic Health Records

The federal government provide additional financial support to Canada Health Infoway Inc. so that *Infoway* develop, in collaboration with the provinces and territories, a national system of electronic health records.

Additional federal funding to *Infoway* amount to $2 billion over a five-year period, or an annual allocation of $400 million.

Evaluation of System Performance

The federal government provide additional annual funding of $50 million to the Canadian Institute for Health Information. In addition, an annual investment of $10 million should be provided to the Canadian Council on Health Services Accreditation. This new federal investment will help establish a national system of evaluation of health care system performance and outcomes, and hence facilitate the work of the National Health Care Commissioner.

Protection of Personal Health Information

The federal government work to achieve greater consistency and/or coordination across federal/provincial/territorial jurisdictions on the following key issues:

- Need-to-know rules restricting access to authorized users based on their purposes;
- Consent rules governing the form and criteria of consent in order to be valid;
- Conditions authorizing non-consensual access to personal health information in limited circumstances and for specific purposes;
- Rules governing the retention and destruction of personal health information;

- Mechanisms for ensuring proper oversight of cross-jurisdictional electronic health record systems.

Canada Health Infoway Inc. and other key investors structure their investment criteria in such a way as to create incentives for developers of EHR systems to ensure practical and pragmatic privacy solutions for implementing the following:

- State-of-the-art security safeguards for protecting personal health information and auditing transactions;
- Shared accountability among various custodians accessing and using EHRs;
- Coordination among custodians to give meaningful effect to patients' rights to access their EHR, rectify any inaccuracy and challenge non-compliance.

Key stakeholders, including the federal, provincial and territorial Ministries of Health, Canada Health Infoway Inc., the Canadian Institute for Health Information and Canadian Institutes of Health Research, undertake the following:

- Rigorous research into the determinants affecting Canadian attitudes regarding acceptable and unacceptable uses of their personal health information;
- Informed and meaningful dialogue with key stakeholders, including patient groups and consumer representatives;
- An open, transparent and iterative public communication strategy about the benefits of EHRs.

CHAPTER ELEVEN

HEALTH CARE HUMAN RESOURCES

The Need for Productivity Studies

Studies be done to determine how the productivity of health care professionals can be improved. These studies should be either undertaken or commissioned by the National Coordinating Committee on Health Human Resources that the Committee recommends be created.

The National Coordinating Committee for Health Human Resources

The federal government work with other concerned parties to create a permanent National Coordinating Committee for Health Human Resources, to be composed of representatives of key stakeholder groups and of the different levels of government. Its mandate would include:

- disseminating up-to-date data on human resource needs;

- coordinating initiatives to ensure that adequate numbers of graduates are being trained to meet the goal of self-sufficiency in health human resources;
- sharing and promoting best practices with regard to strategies for retaining skilled health care professionals and coordinating efforts to repatriate Canadian health care professionals who have emigrated to other countries;
- recommending strategies for increasing the supply of health care professionals from under-represented groups, such as Canada's Aboriginal peoples, and in under-serviced regions, particularly the rural and remote areas of the country;
- examining the possibilities for greater coordination of licensing and immigration requirements between the various levels of government.

Increasing the Supply of Health Human Resources

The federal government:

- Work with provincial governments to ensure that all medical schools and schools of nursing receive the funding increments required to permit necessary enrolment expansion;
- Put in place mechanisms by which direct federal funding could be provided to support expanded enrolment in medical and nursing education, and ensure the stability of funding for the training and education of allied health professionals;
- Review federal student loan programs available to health care professionals and make modifications to ensure that the impact of inevitable increases in tuition fees does not lead to denial of opportunity to students in lower socio-economic circumstances;
- Work with provincial governments to ensure that the relative wage levels paid to different categories of health professionals reflect the real level of education and training required of them.

The federal government work with the provinces and medical and nursing faculties to finance places for students from Aboriginal backgrounds over and above those available to the general population.

In order to facilitate the return to Canada of Canadian health care professionals who are working abroad, the federal government should work with the provinces and professional associations to inform expatriate Canadian health professionals of emerging job opportunities in Canada, and explore the possibility of adopting short-term tax incentives for those prepared to return to Canada.

The federal government contribute $160 million per year, starting immediately, so that Canadian medical colleges can enrol 2,500 first-year students by 2005.

The proposed National Coordinating Committee for Health Human Resources be charged with monitoring the levels of enrolment in Canadian medical schools and make recommendations to the federal government on whether these are appropriate.

The federal government should contribute financially to increasing the number of post-graduate residency positions in medicine to a ratio of 120 per 100 graduates of Canadian medical schools.

The federal government work with the provinces to establish national standards for the evaluation of international medical graduates, and provide ongoing funding to implement an accelerated program for the licensing of qualified IMGs and their full integration into the Canadian health care delivery system.

The federal government phase in funding over the next five years so that by 2008 there are 12,000 graduates from nursing programs across the country, and that the federal government continue to provide full additional funding to the provinces for all nursing school places over and above 10,000, for as long as is necessary to eliminate the shortage of nurses in the country.

The federal government commit $90 million per year from the additional revenue the Committee recommends that it raise in order to enable Canadian nursing schools to graduate 12,000 nurses by 2008.

The federal government commit $40 million per year from the new revenues that the Committee has recommended it raise in order to assist the provinces in raising the number of allied health professionals who graduate each year.

The exact allocation of these funds be determined by the proposed National Coordinating Committee for Health Human Resources.

The federal government devote $75 million per year of the new money the Committee recommends be raised to assisting Academic Health Sciences Centres to pay the costs associated with expanding the number of training slots for the full range of health care professionals.

Review Scope of Practice Rules

An independent review of scope of practice rules and other regulations affecting what individual health professionals can and cannot do be undertaken for the purpose of developing proposals that would enable the skills and competencies of diverse health care professionals to be utilized to the fullest and enable health care services to be delivered by the most appropriately qualified professionals.

CHAPTER TWELVE

NURTURING EXCELLENCE IN CANADIAN HEALTH RESEARCH

Assuming Leadership in Health Research

Health research and its translation into the health care system be routinely on the agendas of meetings of federal and provincial/territorial Ministers and Deputy Ministers of Health, and that the Canadian Institute of Health Research be represented and be involved in setting the agendas for health research at those meetings. This would greatly help to sustain a culture that supports the creation and use of knowledge generated by health research throughout Canada.

The federal government set, on a regular basis, national goals and priorities for health research in collaboration with all stakeholders.

The federal government foster multi-stakeholder collaborations when performing, funding and using health research. This should contribute to capitalizing on the best available resources while minimizing overlap and duplication.

The federal government take a leadership role, through the Canadian Institutes of Health Research and Health Canada, in developing a strategy to encourage the interchange of research scientists between government, academia and the private sector, including national voluntary organizations.

Funding Health Research

The federal government, through both Health Canada and the Canadian Institutes of Health Research, coordinate and provide resources to ensure that Canada contributes to and benefits from the scientific revolution to maximize the economic, health and social gains for Canadians.

The Canadian Institutes of Health Research and Genome Canada fund research that positions Canada as a world leader in the new area of genomics and human genetics so that the health care system can take appropriate advantage of this new technology to improve the health of Canadians.

The Canadian Institutes of Health Research play a leadership role in establishing best practices for addressing the complex ethical issues raised by the use of this new technology in health research and health care.

The federal government:

- Increase, within a reasonable timeframe, its financial contribution to extramural health research to achieve the level of 1% of total Canadian health care spending. This requires an additional investment of $440 million by the federal government;
- Recognize that health research is a long term proposition, and therefore set and adhere to clear long-term plans for funding health research, particularly through the Canadian

Institutes of Health Research. More precisely, the federal government should commit to a five-year planning horizon for the CIHR budget;

- Provide predictable and appropriate investment for in-house health research.

Health Canada:

- Be provided with the financial and human resources in health research that are required to fulfill its mandate and obligations;
- Engage actively in the establishment of linkages and partnerships with other health research stakeholders.

The federal government, through the Canadian Institutes of Health Research, Health Canada and the Canadian Health Services Research Foundation, devote additional funding to health services research and clinical research and that it collaborate with the provinces and territories to ensure that the outcomes of such research are broadly diffused to health care providers, managers and policy-makers.

Health Research on Vulnerable Populations

The federal government, through the Canadian Institutes of Health Research and Health Canada, provide additional funding to health research aimed at the health of particularly vulnerable segments of Canadian society.

The federal government provide additional funding to CIHR in order to increase participation of Canadian health researchers, including Aboriginal peoples themselves, in research that will improve the health of Aboriginal Canadians.

Health Canada be provided with additional resources to expand its research capacity and to strengthen its research translation capacity in the field of Aboriginal health.

The federal government provide increased resources to the Global Health Research Initiative.

Commercializing the Results of Health Research

The federal government require an explicit commitment from all recipients of federally funded health research that they will obtain the greatest possible benefit to Canada, whenever the results of their federally funded research are used for commercial gain.

The Canadian Institutes of Health Research, while not ignoring the social value of health research that does not result in commercial gain, seek to facilitate appropriate economic returns within Canada from the investments it makes in Canadian health research, whenever the results of investments in Canadian health research are used for commercial gain. In doing so, CIHR should develop an innovation strategy aimed at accelerating and facilitating the commercialization of health research outcomes.

The federal government invest additional resources to enhance the output of Canadian health researchers and strengthen the commercialization capacity of performers of federally funded health research through CIHR's innovation strategy. This new funding would be additional to the current health research investment. In particular, the funding of the indirect costs of research by the Canadian granting agencies should be made permanent. Health research performers should be made accountable for the use of these commercialization funds.

Ethics in Health Research

Health Canada initiate, in collaboration with stakeholders, the development of a joint governance system for health research involving human subjects for all research that the federal government performs, that it funds, and that it uses in its regulatory activities.

Health Canada, in the development of this ethics governance system, regard the following components as essential to progress:

- Work initially on all (health) research that the federal government performs, funds, or uses in its regulatory activities, to develop an effective and efficient system of governance that will become accepted as the standard of care across Canada;
- Give prime importance in the governance system to effective education and training mechanisms for all who are involved in research and research ethics, with certification appropriate to their different responsibilities;
- Develop standards, based on the *Tri-Council Policy Statement*, the International Conference on Harmonization guidelines applying to clinical trials involving human subjects, and other relevant Canadian and foreign standards, against which research ethics functions or Research Ethics Boards can be accredited or certified as meeting the levels of function that are consistent with the expectations of Canadians and with those in other countries;
- Ensure that the *Tri-Council Policy Statement* is updated and is maintained at the forefront of international policies for the ethics or research involving humans;
- Remove inconsistencies between the various policies under which research involving humans is now governed, and make Canadian standards consistent with those of other countries that affect Canadian research;
- Establish an accreditation or certification process for research ethics functions that is at arm's length from government, but clearly accountable to government;
- Develop the governance system through open, transparent and meaningful consultation with stakeholders.

All federal departments and agencies require compliance with the standards of the Canadian Council on Animal Care for:

- All research that is carried out in federal facilities, and
- All research that is funded by federal departments or agencies but performed outside federal facilities, and

- All research that is carried out without federal funding or facilities, but that is submitted to or used by the federal government for purposes of exercising its legislated functions.

The Protection of Personal Health Information

Regulations such as those proposed by the Canadian Institutes of Health Research receive their fullest and fairest consideration in discussions about providing greater clarity and certainty of the law with the view to ensure that its objectives will be met without preventing important research to continue to better the health of Canadians and improve their health services.

Discussions continue among stakeholders, the Privacy Commissioner, and those federal and provincial government departments involved with the provision, management, evaluation and quality assurance of health services.

The federal government, through the Canadian Institutes of Health Research and Health Canada, together with other relevant stakeholders, design and implement a program of public awareness to foster in Canadians a broad understanding of:

- the nature of, and reasons for, the extensive databases containing personal health information that must be maintained to operate a publicly financed health care system, and

- the critical need to make secondary use of such databases for health research and health care management purposes.

The federal government, through the Canadian Institutes of Health Research and Health Canada, together with other relevant stakeholders, be responsible for promoting:

- thoughtful discussion and consideration of the ethical issues, particularly informed consent issues, involved in the secondary use of personal health information for health care management and health research purposes;

- thorough examination of the control and review mechanisms needed for ensuring that databases containing personal health information are effectively created, maintained and safeguarded and that their use for health care management and health research purposes is conducted in an open, transparent and accountable manner.

The Canadian Institutes of Health Research, in partnership with industry and other stakeholders, continue to explore the ethical aspects of the interface between the sectors with a view to ensuring that the collaborations and partnerships function in the best interests of all Canadians.

CHAPTER THIRTEEN

HEALTHY PUBLIC POLICY: HEALTH BEYOND HEALTH CARE

National Chronic Disease Prevention Strategies

The federal government, in collaboration with the provinces and territories and in consultation with major stakeholders (including the Chronic Disease Prevention Alliance of Canada), implement a National Chronic Disease Prevention Strategy.

The National Chronic Disease Prevention Strategy build on current initiatives through better integration and coordination.

The federal government contribute $125 million annually to the National Chronic Disease Prevention Strategy.

Specific goals and objectives should be set under the National Chronic Disease Prevention Strategy. The outcomes of the strategy should be evaluated against these goals and objectives on a regular basis.

Public Health Infrastructure

The federal government ensure strong leadership and provide additional funding to sustain, better coordinate and integrate the public health infrastructure in Canada as well as relevant health promotion efforts. An amount of $200 million in additional federal funding should be devoted to this very important undertaking.

CHAPTER FOURTEEN

HOW THE NEW FEDERAL FUNDING FOR HEALTH CARE SHOULD BE MANAGED

The federal government establish an Earmarked Fund for Health Care that is distinct and separate from the Consolidated Revenue Fund. The Earmarked Fund will contain the additional revenue raised by the federal government for investment in health care.

Money from the Earmarked Fund for Health Care be used solely for the purpose of health care. Moreover, such money must be used to buy change or reform: it must be utilized exclusively for expanding public health care coverage and for restructuring and renewal of the publicly funded hospital and doctor system.

The National Health Care Council be charged with the mandate of advising the federal government on how the money in the Earmarked Fund for Health Care should be spent. The Council's advice to the government should be made public through an annual report.

The federal government subject the Earmarked Fund for Health Care to an annual audit by the Auditor General of Canada. The result of such an audit should be made public.

The federal government require the provinces and territories to report annually to the Canadian public on their utilization of federal money from the Earmarked Fund for Health Care.

CHAPTER FIFTEEN

HOW ADDITIONAL FEDERAL FUNDS FOR HEALTH CARE SHOULD BE RAISED

Funding the Recommendations in this Report

The federal government establish a National Variable Health Care Insurance Premium in order to raise the necessary federal revenue to finance implementation of the Committee's recommendations.

Funding Current Federal Expenditures on Health Care

The federal government determine an earmarked revenue source which would fund the approximately 62% of CHST currently regarded as being the federal annual cash contribution to Canada's national health care insurance program.

If the GST is chosen as the earmarked revenue source for the current federal cash contribution to the national hospital and doctor insurance plan, then in order for the federal government to make a significant additional contribution to funding to the current hospital and doctor system, half of all GST revenue (or 3.5 of the 7 percentage points) should be earmarked for health care. (This would be in addition to the increased federal funding required to implement the recommendations in this report.)

The share of the federal annual contribution to which a province/territory is entitled for the purpose of the existing national hospital and doctor program be not only based on the proportion of its population relative to Canada as a whole, but also weighted in some way by the percentage of its population aged 70 years and over.

CHAPTER SIXTEEN

THE CONSEQUENCES OF NOT MAKING THE HEALTH CARE SYSTEM FISCALLY SUSTAINABLE

There are no recommendations in this chapter.

CHAPTER SEVENTEEN

THE *CANADA HEALTH ACT*

The federal government, in collaboration with the provinces and territories, establish a permanent committee – the Committee on Public Health Care Insurance Coverage – made up of citizens, ethicists, health care providers and scientists.

The Committee on Public Health Care Insurance Coverage be given the mandate to review and make recommendations on the set of services that should be covered under public health care insurance.

The Committee on Public Health Care Insurance Coverage report its findings and recommendations to the National Health Care Council.

As its first task, the Committee on Public Health Care Insurance Coverage be charged with developing national standards upon which decisions for public health care coverage will be made.

The Committee on Public Health Care Insurance Coverage be charged with determining the national parameters applicable to post-hospital home care and palliative care delivered in the home.

The federal government enact new legislation establishing the National Health Care Guarantee. The new legislation should include a definition of the concept of "timely access" that will relate to such a guarantee.

The principle of public administration of the *Canada Health Act* be maintained for publicly insured hospital and doctor services. That is, there should be a single insurer – the government – for publicly insured hospital and doctor services delivered by either public or private health care providers and institutions.

The federal government, through Health Canada, clarify the meaning of the concept of public administration under the *Canada Health Act* so as to recognize explicitly that this principle applies to the administration of public health care insurance, not to the delivery of publicly insured health services.

The federal government enact new legislation instituting health care coverage for catastrophic prescription drugs, post-hospital home care and some palliative care in the home. This new legislation should explicitly spell out conditions relating to transparency of decision making and accountability.

APPENDIX B

LIST OF PRINCIPLES FROM VOLUME FIVE (APRIL 2002)

The following principles, enunciated in Volume Five, have guided the Committee in developing the detailed plan of action outlined in this report.

THE INSURER:

1. There should be a single funder (insurer) – the government either directly or through an arm's length agency – for hospital and doctor services covered under the *Canada Health Act*.

2. There should be stability of, and predictability in, government funding for public health care insurance.

3. The federal government should play a major role in sustaining a national health care insurance system.

4. The determination of what should be covered under public health care insurance should be done through an open and transparent process. Health services covered under the *Canada Health Act* should remain publicly insured. Other health services should continue to be funded using a mix of public and private sources, as they are now.

5. The federal government should contribute on an ongoing basis to fund health care technology.

6. The federal government should increase its investment in those areas of health and health care for which it already has a major responsibility.

7. The consequences arising from changes in the level or amount of government funding for hospital and medical care should be clearly understood by government and explained to the public, in as much detail as possible, at the time such changes are made and announced.

THE PROVIDER:

8. In the first stage of health care reform, the method for remunerating hospitals should be changed from the current annual global budget to service-based funding.

9. Regional health authorities should have the responsibility for purchasing hospital services provided by institutions within their region.

10. Primary care renewal should lead to the provision of primary care by group practices, or clinics, which operate twenty-four hours a day, seven days a week.

11. To facilitate primary care reform, the method of compensating general practitioners should be changed from fee-for-service to some form of blended remuneration combining capitation, fee-for-service and other incentives or rewards.

12. New scope of practice rules and other measures need to be developed in order to enable all health care providers in the primary care sector to provide the full range of services for which they have been trained.

13. In the second stage of health care reform, an "internal market" should probably be created in which primary health care teams would purchase health services provided by hospitals and other health care institutions on behalf of their patients.

14. A national (not exclusively federal) strategy must be developed to achieve both an adequate supply and optimal use of health care providers.

THE EVALUATOR:

15. Accountability and transparency in health care financing and delivery require the deployment of a system of electronic health records (EHR) that can capture and translate information on system performance and outcomes.

16. Measuring treatment outcomes and system performance must become an essential part of the health information system. Such monitoring and evaluation of the health care delivery system should be performed independently at the national (not federal) level and be funded by government.

THE PATIENT:

17. Canada's publicly funded health care system should be patient-oriented.

18. Incentives should be developed to encourage patients to use the hospital and doctor system as efficiently as possible. Such incentives should not include user fees for services that are deemed to be medically necessary.

19. Programs that enable people to be responsible for their own health and to stay healthy must be given high priority. The federal government can play a leadership role in this regard.

20. For each type of major procedure or treatment a maximum waiting time should be established, and made public. When this maximum time is reached, the insurer (government) shall pay for the patient to receive immediately the procedure or treatment in another jurisdiction including, if necessary, another country

APPENDIX C

LIST OF WITNESSES

1ST SESSION OF THE 37TH PARLIAMENT

Wednesday, April 24, 2002

Ontario Health Services Restructuring Commission:
Dr. Duncan Sinclair, Former Commissioner

Thursday, April 25, 2002

Health Canada:
Marcel Nouvet, Assistant Deputy Minister, Information Analysis and Connectivity Branch
Michel Léger, Executive Director, Strategic Alliances and Priorities Division, Information Analysis and Connectivity Branch

Wednesday, May 1, 2002

Canadian Institute for Health Information:
Michael Decter, Chairman, Board of Directors

Monday, May 6, 2002

Calgary Health Region:
Jack Davis, President and CEO

As an individual:
Claude Forget, Former Minister of Health, Province of Quebec
Dalhousie University:
Dr. Nuala Kenny, Professor of Pediatrics and Chair, Department of Bioethics

St. Michael's Hospital:
Jeffrey Lozon, President and CEO

As an individual:
Graham Scott, Former Deputy Minister of Health, Province of Ontario

Royal Columbian Hospital:
Dr. Les Vertesi, Medical Director

Wednesday, May 8, 2002

As an individual:
The Honourable Monique Bégin, P.C.

Thursday, May 9, 2002

Dalhousie University:
Professor Lawrence Nestman, School of Health Services Administration

Wednesday, May 22, 2002

Canadian Medical Association:
Dr. Peter Barrett, Past President
Dr. Susan Hutchison, Chair, GP Forum

Ontario Medical Associaiton:
Dr. Elliot Halparin, President
Dr. Kenneth Sky, Past President

Ontario Hospital Association:
Mark Rochon, Member, Advocacy Committee

Association of Canadian Academic Health Care Organizations:
Glenn G. Brimacombe, CEO

University Health Network:
Kevin Empey, Chief Financial Officer

Wednesday, May 29, 2002

Capital Health Authority:
Dr. Ken Gardener, Vice-President, Medical Affairs

Ontario Family Health Network:
Dr. Ruth Wilson, Chair
Donna Segal, CEO

Thursday, May 30, 2002

McMaster University – Centre for Health Economics and Policy Analysis (CHEPA):
Dr. Brian Hutchison

University of Guelph:
Professor Brian Ferguson, Department of Economics

Monday, June 3, 2002

University of Toronto, Department of Health Policy, Management and Evaluation:
Professor Raisa Deber

University of British Columbia:
Professor Roberts G. Evans

Canadian Taxpayers Federation:
Walter Robinson, Federal Director

The Conference Board of Canada:
Paul Darby, Director, Economic Forecasting

As an individual:
David Kelly

Wednesday, June 5, 2002

Canadian Healthcare Association:
Sharon Sholzberg-Gray, President and CEO
Larry Odegard, CEO, Forum

Canadian Association of Chain Drug Stores:
Lori Turik, Vice-President, Public Affairs
Deb Saltmarche, Director of Pharmacy

Thursday, June 6, 2002

Canadian Nurses Association:
Ginette Lemire Rodger, President
Robert Calnan, President-Elect

Canadian Practical Nurses Association:
Kelly Kay, Representative

Wednesday, June 12, 2002

C.D. Howe Institute:
Jack Mintz, President and CEO

Thursday, June 13, 2002

Association of Canadian Academic Health Care Organizations:
Glenn Brimacombe, CEO

St.Michael's Hospital:
Jeffrey Lozon, President and CEO

McGill University Health Centre:
Dr. Hugh Scott, Executive Director

Applied Management:
Bryan Ferguson, Partner

Fraser Group:
Ken Fraser

Tristat Resources:
Richard Shillington, Principal

Monday, June 17, 2002 (9:00 a.m.)

(By videoconference)
Government of Denmark:
John Erik Petersen, Head of Department, Ministry of Health and the Interior
Dr. Steen Friberg Nielsen, CEO, Top Management Academy
Morten Hjulsager, Head of Department, National Informatics, National Board of Health
Dr. Arne Kverneland, Head of Division of Medical Informatics, National Board of Health

Monday, June 17, 2002 (12:30 p.m.)

Government of New Brunswick, Department of Health and Wellness:
Cheryl Hansen, Director, Extra-Mural Program

University of Toronto, Home Care Evaluation Research Centre:
Peter Coyte, Co-Director

Hollander Analytical Services:
Marcus Hollander

Canadian Council of Chief Executives:
David Stewart-Patterson, Senior Vice President, Policy

VOLUME FIVE (October 15, 2001 – March 7, 2002)

Monday, October 15, 2001

University of Manitoba:
Linda West, Professor, Asper School of Business

Frontier Centre for Public Policy:
Peter Holle, President

Western Canadian Task Force on Health Research and Economic Development:
Dr. Henry Friesen, Team Leader
Dr. John Foerster
Dr. Audrey Tingle
Chuck Laflèche

Regional Health Authorities of Manitoba
Bill Bryant, Chair, Council of Chairs
Kevin Beresford, Chair, Council of CEOs
Randy Lock, Executive Director

Manitoba Centre for Health Policy and Evaluation:
Dr. Nora Lou Roos

Women's Health Clinic:
Madeline Boscoe, Advocacy Coordinator

Hospice and Palliative Care Manitoba:
Dr. Paul Henteleff, Chair, Advocacy Committee
John Bond, Member of Advocacy Committee
Margaret Clarke, Executive Director

Canadian Union of Public Employees in Manitoba (CUPE):
Paul Moist, President
Lorraine Sigurdson, Health Care Coordinator

Société franco-manitobaine:
Daniel Boucher, Chief Executive Officer

As a walk-on:
Barry Shtatleman

Tuesday, October 16, 2001

Saskatchewan Registered Nurses' Association:
June Blau, President

Victorian Order of Nurses:
Bob Layne, Vice-President, Planning and Government Relations (Western Region)
Lois Clark, Executive Director, VON North Central Saskatchewan
Brenda Smith, National Board Member (Saskatchewan)

Community Health Services (Saskatoon) Association:
Kathleen Storrie, Vice-President
Ingrid Larson, Director, Member Relations

As an individual:
Dr. John Bury

Canadian Union of Public Employees (CUPE) Saskatchewan:
Tom Graham, President, CUPE Saskatchewan
Stephen Foley, President, Health Care Council
John Welden, Health Care Coordinator, Health Care Council

Saskatoon Chamber of Commerce:
Dave Ductchak, President
Kent Smith-Windsor, Executive Director
Jodi Blackwell, Research and Operations Director

Arthritis Society of Saskatchewan:
Sherry McKinnon, Executive Director
Joy Tappin, Board Member

Canadian Parks and Recreation:
Randy Goulden, Executive Director, Tourism Yorkton

Métis National Council:
Gerald Morin, President
Don Fidler, Director, Health Care

Wednesday, October 17, 2001

Premier's Advisory Council on Health (Alberta):
The Right Honourable Don Mazankowski, P.C., Chair
Peggy Garritty

Department of Health and Social Services (Nunavut):
The Hon. Edward Picco, Minister

Calgary Health Region:
Jack Davis, CEO

Capital Health Authority:
Sheila Weatherill, President and CEO

Canadian Practical Nurses Association:
Pat Fredrickson, President

University of Alberta - Faculty of Nursing:
Dr. Donna Wilson

Health Sciences Association of Alberta:
Elisabeth Ballermann, President

Alberta Association of Registered Nurses:
Sharon Richardson, President

United Nurses of Alberta:
Heather Smith, President

Friends of Medicare:
Christine Burdett, Provincial Chair
Tammy Horne, Member

As an individual:
Kevin Taft, MLA

Western Canada Waiting List Project:
John McGurran, Project Director

Primary Care Initiative:
Dr. June Bergman

Alberta Consumers Association:
Wendy Armstrong

Fédération des communautés francophones et acadiennes du Canada :
George Arès, President

National Advisory Council on Aging:
Pat Raymaker, Chairwoman

Alberta Council on Aging:
Neil Reimer, Secretary/Treasurer

Nechi Institute:
Ruth Morin, Chief Executive Officer
Richard Jenkins, Director of Marketing and Health Promotion

Executive of the Alberta and Northwest Conference of the United Church of Canada - Health Advisory Committee:
Louise Rogers
Kent Harold
Don Junk

As a walk-on:
Noel Somerville

Thursday, October 18, 2001

Commission on Medicare, Saskatchewan:
Ken Fyke, Former Chair

Tommy Douglas Research Institute:
Dave Barrett, Chair
Marc Eliesen, Co-Chair

Market-Media International Corporation:
Joan Gadsby, President

University of British Columbia, Family Practice Residency Program:
Dr. J. Galt Wilson, Program Director - Prince George Site

University of British Columbia:
Dr. John A. Cairns, Dean of Medicine
Dr. Joanna Bates, Associate Dean, Admissions

Health Professions Council:
Dianne Tingey, Member
Gerry Fahey, Research Director

Cambie Surgery Centre:
Dr. Brian Day, Founder

As an individual:
Cynthia Ramsay, Health Economist

Health Association of British Columbia:
Lorraine Grant, Chair of the Board of Directors
Lisa Kallstrom, Executive Director

University of British Columbia:
Dr. John H. V. Gilbert, Coordinator of Health Sciences

University of British Columbia - Vancouver Hospital and Health Sciences Centre:
Professor Charles Wright, Director, Centre for Clinical Epidemiology and Evaluation

University of British Columbia – Centre for Health Services and Policy Research:
Professor Barbara Mintzes

Professional Association of Residents of British Columbia:
Dr. Kristina Sharma

Friday, October 19, 2001

Canadian Medical Association:
Dr. Peter Barrett, Past President
Dr. Arun Garg, Chair, Council on Health Policy and Economics

British Columbia Medical Association:
Dr. Heidi Oetter, President
Darrell Thomson, Director, Economics and Policy Analysis

University of British Columbia, Anxiety Disorders Unit, Department of Psychiatry:
Dr. Peter D. McLean, Professor and Director

Maples Surgical Centre (Manitoba)
Dr. Mark Godley

Monday, October 29, 2001

Canadian Radiation Oncology Services:
Dr. Thomas McGowan, President and Medical Director

Canadian Taxpayers Federation:
Walter Robinson, Federal Director

Canadian Council of Churches:
Stephen Allen, Member of Commission for Justice and Peace and Co-Chair of the Commission's Ecumenical Health Care

Buffett Taylor Employee Benefits and Workplace Wellness Consultants:
Edward Buffett, President and CEO

As an individual:
Michael Rachlis

Medical Reform Group:
Dr. Joel Lexchin

At Work Health Solutions Inc.:
Dr. Arif Bhimji, Founder and President; Medical Director of Liberty Health
Gery Barry, President and CEO of Liberty Health

Consumers' Association of Canada:
Jean Jones, Chair of the Health Committee
Mel Fruitman, President

Ontario Association of Optometrists:
Dr. Joseph Chan

Medical Devices Canada (MEDEC):
Peter Goodhand, President

AstraZeneca:
Gerry McDole, President and CEO

Comcare Health Services:
Mary Jo Dunlop

Saint Michael's Hospital:
Jeffrey Lozon, President and CEO

Association of Ontario Health Centres:
Gary O'Connor, Executive Director

Ontario Medical Association:
Kenneth Sky, President

The Arthritis Society:
Denis Morrice, President and CEO

SMARTRISK:
Dr. Robert Conn, President and CEO

Canadian Cancer Society:
Dr. Barbara Whylie, Director, Cancer Control Policy
Cheryl Mayer, Director, Cancer Control Programs, Alcohol and Drug Recovery Association of Ontario, and Addiction Intervention Association
Jeff Wilbee, Executive Director

Tuesday, October 30, 2001

Canadian Institute for Health Information:
Michael Decter, Chairman, Board of Directors

Ontario Hospital Association:
David MacKinnon, President and CEO

Registered Nurses Association of Ontario:
Doris Grinspun, Executive Director

McMaster University Department of Economics:
Jeremiah Hurley, Professor

University of Toronto Public Health Science Department:
Dr. Cameron Mustard, Professor

University of Toronto:
Colleen Flood, Professor

Drug Trading Company Limited:
Larry Latowsky, President and CEO
Jane Farnharm, Vice President, Pharmacy

Canadian Pharmacists Association:
Ron Elliott, President

GlaxoSmithKline:
Geoffrey Mitchinson, Vice-president, Public Affairs

Medtronic:
Donald A. Hurley, President

Canadian Association for the Fifty Plus:
Dr. Bill Gleberzon, Associate Executive Director
Lilian Morgenthal, President

Canadian Association for Community:
Cheryl Gulliver, President
Connie Laurin-Bowie
Margot Easton

Roeher Institute:
Cameron Crawford, President

As individuals:
Clement Edwin Babb
Robert S.W. Campbell

Wednesday, October 31, 2001

As individuals:
The Honourable Claude Forget
The Honourable Claude Castonguay
André-Pierre Contandriopoulos, Professor, Faculty of Medicine, University of Montreal

Hôtel Dieu Hospital:
Dr. Serge Boucher

Conseil du patronat du Québec:
Gilles Taillon, President

Canadian Chamber of Commerce:
Nancy Hughes-Anthony, President and Chief Executive Officer
Michael N. Murphy, Senior Vice-President, Policy

As individuals:
Jean-Luc Migué
Lee Soderstrom, Professor, Department of Economics, McGill University

Montreal Economic Institute:
Michel Kelly-Gagnon, Executive Director
Dr. Edwin Coffey, Retired Associate Professor, Faculty of Medicine, McGill University, and Former President of the Quebec Medical Association

Frosst Health Care Foundation:
Dr. Monique Camerlain, President of the Board of Directors
Janet Dunbrack, Executive Director.

Thursday, November 1, 2001

Association des optométrists du Québec:
Dr. Langis Michaud, President
Marie-Josée Crête, Deputy Director General
Clairmont Girard, Advisor

Collège des médécins du Québec:
Dr. Yves Lamontagne, President
Dr. André Garon, Deputy Secretary General

As an individual:
Robert Dorion

Canadian Life and Health Insurance Association:
Mark Daniels, President
Greg Traversy, Executive Vice-President
Yves Millette, Senior Vice-President, Quebec Affairs
Frank Fotia, Vice-President, Group Insurance.

As individuals:
Dr. Margaret Somerville, Acting Director, McGill Centre for Medicine, Ethics and Law, McGill University
Dr. Robyn Tamblyn, Associate Professor, Department of Economics, McGill University

Merck Frosst Canada Ltd.:
Kevin Skilton, Director, Policy Planning
Dr. Terrance Montague, Executive Director, Patient Health

Association québécoise des droits des retraités (AQDR):
Ann Gagnon, Advisor on Health
Yollande Richer, Vice-President, Communications
Myroslaw Smereka, Director General

Monday, November 5, 2001

Department of Health and Community Services, Newfoundland:
Robert C. Thompson, Deputy Minister
Beverly Clarke, Assistant Deputy Minister

Victorian Order of Nurses (VON Canada):
Patricia Pilgrim, President, St. John's Branch
Bernice Blake Dibblee, Executive Director, St. John's Branch

Association of Registered Nurses of Newfoundland and Labrador:
Sharon Smith, President

Canadian Union of Public Employees, Newfoundland:
Wayne Lucas, President

As an individual:
Maud Peach

National Cancer Institute of Canada:
Dr. Roy West, President

Health and Community Services, Newfoundland:
Dr. Catherine Donovan

Weight Watchers:
Marlene Bayers, Regional Manager

Newfoundland Cancer Treatment and Research Foundation:
Bertha H. Paulse, Chief Executive Officer

As an individual:
Karen McGrath, Executive Director of Health and Community Services St. John's Region

Tuesday, November 6, 2001

Canadian Auto Workers (CAW):
Cecil Snow, President, Nova Scotia Health Care Council

Nova Scotia Association of Health Organizations:
Robert Cook, President and CEO

Insurance Bureau of Canada:
George Anderson, President and CEO
Paul Kovacs, Senior Vice-President, Policy, and Chief Economist

Canadian Coalition Against Insurance Fraud:
Mary Lou O'Reilly, Executive Director

Atlantic Institute for Market Studies:
Dr. David Zitner, Fellow on Health Policy

Dalhousie University:
Nuala Kenny, Professor of Pediatrics and Chair, Department of Bioethics
Dr. Vivek Kusumakar, Head, Mood Disorders Research Group, Department of Psychiatry
Lawrence Nestman, Professor, School of Health Services Administration

Nova Scotia Valley Caregivers Support Group:
Maxine Barrett

Elizabeth May Chair in Women's Health and the Environment, Dalhousie University:
Sharon Batt, Chair

Feminists for Just and Equitable Public Policy:
Ms. Georgia MacNeil, Chair Person

Cape Breton Regional Health Care Complex:
John Malcom, CEO
Dr. Mahmood Naqvi, Medical Director, Cape Breton Regional Facility

Capital District Health Authority:
Dr. John Ruedy, Vice-President, Academic Affairs

Dalhousie University:
Thomas Rathwell, Professor and Director, School of Health Services Administration

Canadian Medical Association:
Dr. Henry Haddad, MD, President
Bill Tholl, Secretary General
Dr. Bruce Wright, President of the Medical Society of Nova Scotia
Dr. Dana W. Hanson, President-Elect

Dalhousie University:
Dr. Desmond Leddin, Head, Division of Gastroenterology
Dr. George Kephart, Director, Population Health Research Unit, Department of Community and Epidemiology
Dr. Kenneth Rockwood, Faculty of Medicine, Division of Geriatric Medicine

Cobequid Community Health Board:
Ryan Sommers

Health Canada:
Anne-Marie Leger, Policy Analyst

Wednesday, November 7, 2001

Department of Health and Social Services, Prince Edward Island:
The Honourable Jamie Ballem, Minister

PEI Seniors Advisory Council:
Heather Henry-MacDonald, Chair

Canadian Union of Public Employees, PEI Division:
Bill A. McKinnon, National Representative
Ms. Donalda MacDonald, President
Raymond Léger, Research Representative

Department of Health and Social Services:
Mary Hughes-Power, Director of Acute and Continuing Care

Deborah Bradley, Manager of Public Health Policy

College of Family Physicians of Canada:
Dr. Peter MacKean, Chairman of the Board

Queen Elizabeth Hospital:
Iain Smith, Drug Utilization Coordinator

PEI Pharmacy Board:
Neila Auld, Executive Director, PEI

Queen's Regional Health Authority:
Sylvia Poirier, Chair

West Prince Regional Health Authority:
Ken Ezeard, Chief Executive Officer

Department of Health and Social Services:
Dr. Don Ling, Director of Medical Services

Department of Health and Social Services, Prince Edward island:
Rory Francis, Deputy Minister
Bill Harper, Assistant Deputy Minister
Jean Doherty, Communications Coordinator

Southern Kings Health Authority:
Betty Fraser, Chief Executive Officer

Department of Health and Social Services:
Susan Maynard, Senior Health Planner
Kathleen Flanagan-Rochon, Community Services Coordinator

Evangeline Health Centre:
Elise Arsenault, Coordinator

East Prince Regional Health Authority:
David Riley, Chief Executive Officer

Dalhousie University:
Dr. Stan Kutcher, Department Head of the Community Health and Epidemiology/ Psychiatry

Thursday, November 8, 2001

Faculty of Nursing, University of New Brunswick:
Dr. Margaret Dykeman

New Brunswick Health Care Association:
Robert Simpson, Chief Executive Officer

Canadian Association of Chain Drug Stores:
Sherry Porter, Atlantic Canada Representative
Sandra Aylward, Vice President, Pharmacy Services

As individuals:
Dr. Russell King, Former Minister of Health, Province of New Brunswick
William Morrissey, Former Deputy Minister of Health, Province of New Brunswick

Applied Management:
Bryan Ferguson, Partner

Société des Acadiens et Acadiennes du Nouveau-Brunswick:
Daniel Thériault, Director General

Canadian Snowbird Association:
Bob Jackson, President

New Brunswick Senior Citizens Federation Inc.:
Helen Ladouceur, Member
Eilleen Malone, Member

Catholic Health Association of Canada:
Sandra Keon, Secretary Treasurer; and Vice-President of Clinical Programs, Pembroke Hospital

Miramichi Police Force:
Michael Gallagher, Corporal, Drug Section

Canadian Union of Public Employees, New Brunswick:
Raymond Léger, Research Representative

Federal Superannuates National Association:
Rex G. Guy, National President
Roger Heath, Research and Communications Officer

Union of New Brunswick Indians:
Nelson Solomon, Director of Health
Wanda Paul Rose, Coordinator
Norville Getty, Consultant

Nurses Association of New Brunswick:
Roxanne Tarjan, Director General

Thursday, February 21, 2002

Canadian Federation of Nurses Unions:
Kathleen Connors, President

Canadian Health Coalition:
Dr. Arnold Relman, Former editor of *New England Journal of Medicine*
Michael McBane, National Coordinator

Federal Superannuates National Co-ordinator:
Rex G. Guy, National President
Roger Heath, Research and Communications Officer

Thursday, March 7, 2002

Canadian Healthcare Association:
Sharon Sholzberg-Gray, President and CEO
Kathryn Tregunna, Director, Policy Development

Canadian Labour Congress:
Kenneth V. Georgetti, President
Cindy Wiggins, Senior Researcher, Social and Economic Policy Department

VOLUME THREE (May 28, 2001 – June 14, 2001)

Monday, May 28, 2001
(By videoconference)

From the Ministry of Health, Welfare and Sports of the Netherlands:
Dr. Hugo Hurts, Deputy Director, Health Insurance Division, Ministry of Health, Welfare and Sports of the Netherlands

From the International Institute of Social Studies of the Netherlands:
Professor James Bjorkman

Thursday, June 7, 2001 (9:00 a.m.)
(by videoconference)

Swedish Parliament (Riksdag):
Lars Elinderson, Deputy member, Committee on Health and Welfare

Monday, June 11, 2001
(By videoconference)

German Health Ministry:
Georg Baum, Director General, Head of Directorate Health Care
Dr. Margot Faelker, Deputy-Director, Section Financial Issues of Statutory Health Insurance
Dr. Rudolf Vollmer, Director-General, Head of Directorate Long-Term Nursing Care Insurance

Department of Health – Economic and Operational Research Division of the United Kingdom:
Clive Smee, Chief Economic Adviser

University of Birmingham:
Professor Chris Ham, Director, Health Services Management Centre

London School of Economics:
Professor Julien LeGrand, Richard Titmuss Professor of Social Policy, LSE Health & Social Care

Tuesday, June 12, 2001
(By videoconference)

Australian Institute of Health and Welfare:
Dr. Richard Madden, Director

Australian Health Insurance Association:
Russel Schneider, CEO

National Centre for Epidemiology and Population Health – Australian National University
Dr. Tony Adams, Professor of Public Health

Health Insurance Commission:
Dr. Brian Richards

Australian Medical Association:
Dr. Carmel Martin, Director
Dr. Roger Kilham

Wednesday, June 13, 2001

Health Canada:
Ake Blomqvist, Visiting Academic, Applied Research and Analysis Directorate, Information, Analysis and Connectivity Branch and Professor, University of Western Ontario

University of Calgary:
Professor Cam Donaldson, Department of Economics

University of Toronto (by videoconference):
Professor Colleen Flood, Faculty of Law

As an individual:
Claude Forget

University of Toronto:
Professor Mark Stabile, Department of Economics
Professor Carolyn Tuohy, Department of Political Science

Thursday, June 14, 2001
(by videoconference)

U.S. Department of Health and Human Services:
Christine Schmidt, Deputy to the Deputy Assistant Secretary for Health Policy, Office of the Assistant Secretary for Planning and Evaluation
Ariel Winter, Analyst
Tanya Alteras, Analyst

VOLUME TWO (March 21 2001 - June 7 2001)

Wednesday, March 21, 2001

Statistics Canada:
Réjean Lachapelle, Director, Demography Division
Jean-Marie Berthelot, Manager, Health Analysis and Modeling Group, Social and Economic Studies Division
Brian Murphy, Senior Research Analyst, Socio-Economic Modeling Group

Canadian Institute of Actuaries:
David Oakden, President
Rob Brown, Manager of Task Force on Health Care Financing
Daryl Leech, Chair, Committee on Health Care

National Advisory Council on Aging:
Dr. Michael Gordon, Member

Conference Board of Canada:
James G. Frank, Ph.D., Chief Economist and Vice-President
Glenn Brimacombe, Director of Health Program

Thursday, March 22, 2001

C.D. Howe Institute:
William B.P. Robson, Vice-President and Director of Research

McMaster University:
Byron G. Spencer, Professor

University of Ottawa:
Dr. William Dalziel

Wednesday, March 28, 2001

IMS Health Canada:
Dr. Roger A. Korman, President

Canadian Association of Pharmacists:
Dr. Jeff Poston, Executive Director

Health Promotion Research:
Dr. Robert Coambs, President and CEO

Health Canada:
Barbara Ouellet, Director of Home Care and Pharmaceuticals, Health Care Directorate, Policy and Consultation Branch

Thursday, March 29, 2001

Canadian Association of Radiologists:
Dr. John Radomsky
Thursday, March 29, 2001 (cont'd)

Canadian Coordinating Office for Health Technology Assessment (CCHOTA):
Dr. Jill Sanders, President and CEO

The Fraser Institute:
Martin Zelder, Director of Health Policy Research

As an individual:
Professor David Feeny

Wednesday, April 4, 2001

Health Canada:
Dr. Christina Mills, Director General, Centre for Chronic Disease Prevention and Control – Population Public Health Branch
Dr. Paul Gully, Acting Director General, Centre for Infectious Disease Prevention and Control
Dr. Clarence Clottey, Acting Director, Diabetes Division, Bureau of Cardio-Respiratory Diseases and Diabetes, Centre for Chronic Disease prevention and Control
Nancy Garrard, Director, Division of Aging and Seniors

Dalhousie University:
Dr. David MacLean, Departmental Head, Community Health and Epidemiology

Thursday, April 5, 2001

Health Canada:
Abby Hoffman, Director General, Health Care Directorate – Health Policy and Communications Branch
Cliff Halliwell, Director General, Applied Research & Analysis Directorate, Information, Analysis and Connectivity Branch
Nancy Garrard, Director, Division of Aging and Seniors

Thursday, April 26, 2001
Canadian Institute of Health Research:
Dr. Alan Bernstein, President

Health Canada:
Kimberly Elmslie, Acting Executive Director, Health Research Secretariat

Statistics Canada:
T. Scott Murray, Director General, Institutions and Social Statistics Branch

Wednesday, May 9, 2001

Canada's Research-Based Pharmaceutical Companies:
Murray Elston, President

Coalition for Biomedical and Health Research:
Dr. Barry McLennan, Chairman
Charles Pitts, Executive Director

Centre for Excellence for Women's Health:
Dr. Pat Armstrong

Canadian Genetic Diseases Network:
Dr. Ronald Worton, CEO & Scientific Director

Thursday, May 10, 2001

Health Canada:
William J. Pascal, Director General, Office of Health and Information Highway, Information, Analysis and Connectivity Branch

Canadian Institute for Health Information:
Dr. John S. Millar, Vice-President, Research and Analysis

Canadian Society of Telehealth:
Dr. Robert Filler, President

Department of Health and Wellness of New Brunswick
David Cowperthwaite, Director of Information System

Wednesday, May 16, 2001

Canadian Medical Association:
Dr. Peter Barrett, President

Canadian Medical Forum Task Force 1:
Dr. Hugh Scully, President

Federal Provincial Territorial Advisory Committee on Health Human Resources:
Dr. Thomas Ward, Chair

Canadian Nurses Association:
Sandra MacDonald-Remecz, Director of Policy, Regulation and Research

Canadian Federation of Nurses Unions:
Kathleen Connors, President

Ordre des infirmières et infirmiers auxiliaires du Québec:
Régis Paradis, President

Nurse Practitioners Association of Ontario:
Linda Jones

Canadian Radiation and Imaging Societies in Medicine (CRISM):
Dr. Paul C. Johns, Past Chair

The Canadian Chiropractic Association:
Dr. Tim St. Dennis, President

Canadian Society for Medical Laboratory Science:
Kurt Davis, Executive Director

Thursday, May 17, 2001

Canadian Home Care Association (CHCA):
Nadine Henningsen, Executive Director

Canadian Association for Community Care (CACC):
Dr. Taylor Alexander, President

Victorian Order of Nurses for Canada (VON Canada):
Diane McLeod, Vice-President, Policy, Planning and Government Relations, Central Region

Wednesday, May 30, 2001

Health Canada:
Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch
Jerome Berthelette, Special Advisor, Office of the Special Advisor Aboriginal Health, First Nations Inuit Health Branch
Dr. Peter Cooney, Acting Director General, Non-Insured Health Benefits, First Nations and Inuit Health

Indian and Northern Affairs Canada:
Chantal Bernier, Assistant Deputy Minister, Socio-economic Development Policy and Programs
Terry Harrison, Director, Social Services and Justice

Assembly of First Nations:
Elaine Johnston, Director of Health

Métis National Council:
Gerald Morin, President

Native Women's Association of Canada:
Michelle Audette, Interim Speaker and President of the Native Women Association of Quebec

Congress of Aboriginal Peoples:
Scott Clark, President, United Native Nations

Inuit Tapirisat of Canada:
Larry Gordon, Member ITC, Health Committee

Pauktuutit Inuit Women's Association:
Veronica N. Dewar, President

National Aboriginal Health Organization:
Dr. Judith Bartlett, Chair
Richard Jock, Executive Director

Canadian Institutes of Health Research:
Dr. Jeff Reading, Scientific Director, Institute of Aboriginal People's Health

Wikwemikong Health Centre:
Ron Wakegijig, Healer

National Indian and Inuit Community Health Representatives Organization:
Margaret Horn, Executive Director

Thursday, May 31, 2001

Health Canada:
Dr. John Wooton, Special Advisor on Rural Health, Population and Public Health Branch

Canadian Medical Association:
William Tholl, Secretary General and Chief Executive Officer

Society of Rural Physicians of Canada:
Dr. Peter-Hutten-Czapski, President

Consortium for Rural Health Research:
Dr. Judith Kulig

Wednesday, June 6, 2001

University of Ottawa:
Professor Martha Jackman, Faculty of Law

University of Calgary: (by videoconference)
Professor Sheilah Martin, Faculty of Law

Thursday, June 7, 2001 (11:00 a.m.)

Health Canada:
Nancy Garrard, Acting Director General, Centre for Healthy Human Development, Population and Public Health Branch
Tom Lips, Senior Policy Advisor for Mental Health, Population and Public Health Branch
Carl Lakaski, Senior Analyst, Mental Health, Health Human Resources Strategies Division, Health Policy and Communications Branch

Canadian Psychological Association:
Dr. John Service, Executive Director

Canadian Alliance on Mental Illness and Mental Health:
Phil Upshall, Coordinator

Canadian Mental Health Association:
Bonnie Pape

Department of Health and Wellness of New Brunswick:
Ken Ross, Assistant Deputy Minister, Mental Health Services

VOLUME ONE (March 2 200 – September 21, 2001)
(2nd Session, 36th Parliament)

Thursday, March 2, 2000

University of Toronto, Department of Health Administration:
Raisa Deber, Professor

Health Canada:
Dr. Robert McMurtry, *G.D.W.* Cameron Visiting Chair

Health Action Lobby (HEAL):
Sharon Sholzberg-Gray, Co-Chair

Dr. Mary Ellen Jeans, *Co-Chair*

Canadian Policy Research Network:
Sholom Glouberman, Director, Health Network

Wednesday, March 22, 2000

Founder's Network :
Dr. Fraser Mustard

Goldfarb Consultants:
Dr. Scott Evans, Senior Statistical Consultant

Environics Research Group :
Chris Baker, Vice-President

Health Canada:
Wendy Watson-Wright, Director General, Policy and Major Projects Directorate, Health Promotion and Programs Branch

Thursday, March 23, 2000

Health Canada:
Sylvain Paradis, Acting Policy Group Manager, Policy and Major Projects Directorate, Quantitative Analysis and Research Section, Health Promotion and Programs Branch
Liz Kusey, Policy Analyst, Policy and Major Projects Directorate, Health Promotion and Programs Branch
Monique Charon, Acting Director, Program Policy and Planning, Program Policy, Transfer Secretariat and Planning Directorate, Medical Services Branch
Mary Johnston, Education Consultant, Strategic Policy and Systems Coordination Section, Childhood and Youth Division – Health Promotion and Programs Branch
Julie MacKenzie, Senior Research Analyst, Strategic Policy and Systems Coordination Section, Childhood and Youth Division – Health Promotion and Programs Branch

Queens University – School of Policy Studies:
Keith Banting, Director

Thursday, April 6, 2000

University of British Columbia:
Robert G. Evans, Director, Population Health Program

Canadian Centre for Policy Alternatives:
Colleen Fuller

The Fraser Institute:
Martin Zelder, Director of Health Policy Research

Wednesday, May 3, 2000

Health Canada:
Cliff Halliwell, Director General, Applied Research & Analysis Directorate, Information, Analysis and Connectivity Branch
Abby Hoffman, Senior Policy Advisor
Frank Fedyk, Acting Director, Canada Health Act Directorate, Policy and Consultation Branch

Thursday, May 4, 2000

As an individual:
Tom Kent

University of Toronto:
Michael Bliss, Professor

Wednesday, May 10, 2000

University of Western Ontario:
Ake Blomqvist, Professor

University of Toronto:
Colleen Flood, Professor
Mark Stabile, Professor

Thursday, May 11, 2000

Canadian Institute for Health Information:
John S. Millar, Vice-President, Research and Analysis

McGill University:
Margaret Somerville, Professor

Alberta University:
Laura Shanner, Professor

Wednesday, May 17, 2000

As an individual:
The Honourable Marc Lalonde, P.C.

Wednesday, May 31, 2000

As an individual:
The Honourable Monique Bégin, P.C.

Wednesday, June 7, 2000

Department of Finance:
Guillaume Bissonnette, General Director, Federal-Provincial Relations and Social Policy Branch
Barbara Anderson, Director, Federal-Provincial Relations Division - Federal-Provincial Relations and Social Policy Branch

Thursday, September 21, 2000

As an individual:
Graham Scott, Former Deputy Minister of Health, Province of Ontario

◆ ◆ ◆

OTHER WRITTEN SUBMISSIONS RECEIVED:

Abell Medical Clinic
Alberta Centre for Injury Control and Research
Amgen Canada Inc.
Ancaster-Dundas-Flamborough-Aldershot New Democratic Party Riding Association Executive Committee
Association of Canadian Medical Colleges (ACMC)
Patricia Baird
B.C. Better Care Pharmacare Coalition
Bruce Bigham
Brain Injury Association of Nova Scotia
Robert D. Brown and Michanne Haynes
Canada Health Infoway
Canada's Research-Based Pharmaceutical Companies
Canada West Foundation
Canadian Association of Emergency Physicians (CAEP)
Canadian Association of Internes and Residents
Canadian Blood Services
Canadian Caregiver Coalition
Canadian Cochrane Network and Centre

Canadian Council on Integrated Healthcare
Canadian Dental Hygienists Association
Canadian Drug Manufacturers Association (CDMA)
Canadian Strategy for Cancer Control
Cancer Care Ontario, Division of Preventive Oncology
Chemical Sensitivities Information Exchange Network Manitoba (CSIENM)
Conestoga College (Pat Bower, Course instructor)
Laurent Desjardins
Faith Partners (Ottawa)
Federation of Medical Women in Canada
Sandra Finley
Dr. Michael Gordon, Baycrest Centre for Geriatric Care
Serena Grant
Health Care Corporation of St.John's
Heart and Stroke Foundation of New Brunswick
Home-based Spiritual Care
Kidney Foundation of Canada
Kids First Parent Association of Canada
Dr. Lee Kurisko
Caterine Lindman
Jim Ludwig
Dr. Keith Martin
Dr. Ross McElroy
Dr. Malcom S. McPhee
Meals on Wheels of Calgary
Medbuy Corporation
Verna Milligan
Moose Jaw-Thunder Creek District Health Board
Dr. Earl B. Morris
Fran Morrison
Multiple Sclerosis Society of Canada
John Neilson
Ontario Chamber of Commerce
Ontario Psychological Association
Roy L. Piepenburg (Liberation Consulting)
Red Deer Network in Support of Medicare
Dr. Robert S. Russell
Society of Obstetricians and Gynaecologists of Canada
Christa Streicher
Thames Valley District Health Council
Elaine Tostevin
University of Ottawa Heart Institute
University of Ottawa Institute of Population Health (Dr. Joseph Losos, Director)